F. READ HOPKINS PEDIATRIC ASSOCIATES, INC.

PATIENT REGISTRATION FORM – PATIENTS 18 YEARS OLD OR OLDER

PATIENT'S INFORMATION

Name: _____ Soc. Sec.# ☐☐☐☐☐☐☐☐☐ Date of Birth_____ Sex____

Street Address_____

City/State/ZIP _____ Email_____

Home Phone _____ Cell Phone_____ Work Phone_____

Employer _____ Occupation _____

Employer's Address _____ _____

Are you a Student? _____ If so, Full-time or Part-time? _____ Where? _____

** I elect to receive appointment reminders by : ☐ TEXT ☐ EMAIL

PATIENT'S INSURANCE INFORMATION

Primary Insurance _____ Identification # _____ Group #_____
Policy Holder's Name _____ Policy Holder's Date of Birth _____
Effective Date _____ Policy Holder's Relationship to Patient _____

Secondary Insurance _____ Identification # _____ Group #_____
Policy Holder's Name _____ Policy Holder's Date of Birth _____
Effective Date _____ Policy Holder's Relationship to Patient _____

WHICH PHARMACY DO YOU USE ? _____

Please present copies of all applicable insurance cards.

Person responsible for payment _____ ***Relationship to Patient*** _____

EMERGENCY CONTACT INFORMATION

Emergency Contacts (List 2 persons)

Name _____ Relationship to patient _____
Address _____
Home Phone _____ Work Phone_____ Cell Phone_____

Name _____ Relationship to patient _____
Address _____
Home Phone _____ Work Phone_____ Cell Phone_____

Name of Person Completing This Form _____
Signature _____ ***Date*** _____

REVISED 7/2018

[redacted] **Reviewed by:** ***Signature*** _____ ***Date:*** _____

F. READ HOPKINS PEDIATRIC ASSOCIATES, INC.

Financial Policy/Record Retention Policy

FINANCIAL POLICY AND ASSIGNMENT OF BENEFITS: We submit charges for services rendered to your insurance company as a courtesy to you. If the patient is covered by one of the health insurance plans with which we participate, we are required by the plan to collect co-payments and deductibles at the time of service. It is imperative that you bring your insurance card and mailing address of your health insurance plan with you to every visit, making us aware of any changes in your coverage. Failure to provide us with current insurance information could result in a reduction of your benefits and higher out-of-pocket costs for you.

I, the undersigned, assign directly to F. Read Hopkins Pediatric Associates, Inc., all medical insurance benefits, if any, otherwise payable to me, for services rendered. Payment in full is due at the time of service unless other arrangements have been made in advance. Any balance not paid at the time of service will be considered an extension of credit and may incur finance charges up to eighteen percent (18%). I understand that I am financially responsible for all charges whether or not paid by insurance, and in the event any amount due remains unpaid after a bill is rendered, I agree to pay a collection penalty of twenty-five percent (25%) of the then principal account balance and any other fees, including reasonable attorney fees. If you pay by check and it is returned for any reason, you will be charged a return check fee as allowed by law. You also agree to allow us, our agent, successors or assigns to turn your check into an electronic transaction at our discretion and to debit your checking account for any return check fees. In order to facilitate prompt payment, we offer several forms of payment. These include cash, check, money order, debit transactions, VISA, MasterCard, Discover, and American Express.

I authorize the release of any medical or incidental information to my insurance carrier to determine benefits payable for services rendered, or to meet insurance requirements for quality assurance. Fax and/or electronic transmission of medical records is allowed if indicated. I certify that the insurance information I have provided to F. Read Hopkins Pediatric Associates is correct.

MEDICAL RECORD RETENTION: I understand that medical records will be retained for a minimum of six years following the last patient encounter. Records of a minor child, including immunizations will be maintained until the child reaches the age of eighteen or becomes emancipated, with a minimum time for record retention of six years from the last patient encounter regardless of the age of the child. The records will then be destroyed in a manner that assures confidentiality throughout the process and in its results.

_____ _____

Signature of Patient Date

_____

Print Name