ISLAND KIDS PEDIATRIC'S PATIENT REGISTRATION

PLEASE PRINT

NAME OF CHILD (PLEASE LIST ALL CHILDREN SEEN BY OUR PHYSICIANS):

_____ MALE OR FEMALE CIRCLE
LAST NAME FIRST MIDDLE DATE OF BIRTH

_____ MALE OR FEMALE CIRCLE
LAST NAME FIRST MIDDLE DATE OF BIRTH

_____ MALE OR FEMALE CIRCLE
LAST NAME FIRST MIDDLE DATE OF BIRTH

MOTHER'S NAME:_____**DATE OF BIRTH**:_____**Phone:**_____
LAST FIRST

FATHER'S NAME:_____**DATE OF BIRTH:**_____**Phone:**_____
LAST FIRST

STREET ADDRESS:_____
ADDRESS CITY/STATE/ZIP

HOME PH:_____**CELL PH:**_____

EMAIL ADDRESS:_____

EMERGENCY CONTACT (OTHER THAN PARENT):

_____ _____PH:_____
NAME RELATIONSHIP

☐ I do ☐ I do not **Give permission for IKP to discuss private (HIPAA) information with the Emergency Contact**.

PROVIDED PATIENT'S INSURANCE CARD : ☐ **Yes** ☐ **No**

PARENT'S INSURANCE INFORMATION:
NAME OF PRIMARY INSURANCE:_____ WHO IS THE PRIMARY INSURANCE HOLDER? _____ PRIMARY INSURED'S DATE OF BIRTH:_____

PHARMACY NAME: _____

STREET ADDRESS: _____
ADDRESS CITY/STATE/ZIP

TELEPHONE #_____ FAX #: _____

INSURANCE REQUIREMENT: Race: ____ White ___Black ___Asian ___ Native Hawaiian/Other Pacific Islander ____Refuse to Report

Ethnicity: _____Hispanic or Latin _____Not Hispanic or Latin _____Refuse to Report

Language: _____English_____Spanish _____Russian_____Indian(Includes Hindi & Tamil) _____Other

Families New to Our Practice: How did you find out about our office/doctors? Friend/Relative ____ REFERRED BY: _____

Internet Search___ SI Parent Magazine____ Other Physician Office____ Who? _____ Other_____

FINANCIAL POLICY ACKNOWLEDGEMENT

We are pleased that you have entrusted our physicians with your health care. In doing so, you can be assured that we are committed to providing you with the best medical care possible. We also appreciate that healthcare coverage can be a complex world and recognize the need to establish a clear and concise financial policy that helps you understand your responsibilities as a patient. As a policyholder of healthcare insurance, it is your responsibility to be an informed consumer and to inform us of any changes with your insurance. Many insurance carriers have "timely filing deadlines." If we are not provided with accurate information at the time of service, you may be responsible for payment in full for all services rendered. Our physicians participate with a variety of health insurance plans. Prior to your visit, it is your responsibility to verify our practice has a contract with your insurance carrier & that our physicians participate with your plan. It is expected that you have an understanding of what your policy covers, know your copayment amounts, deductible and coinsurance amounts. If your insurance carrier requires you to select a Primary Care Physician (PCP), it is also your responsibility to select our office prior to your visit. Any financial portion that is the "member's responsibility" such as co-pay, deductible or a non covered percentage will be collected at the time of service. **If, for any reason, it is not collected at the time of service, $10 late payment fee will be applied and an annual finance charge of 25% will be applied to your outstanding balance.** Remember, your insurance coverage is a contract between you and your insurance company. Our practice is not responsible for services denied by your insurance company. We will do our best to assist you with understanding your proposed treatment and in answering questions relating to your insurance.

Billing & Payment Policy

Our office accepts Visa, American Express, Discover, MasterCard, checks and cash for your convenience. It is our billing policy to file all claims to those insurance carriers in which we are participating providers. **At the time of service, you are responsible for copayments, co-insurance, deductibles and any non covered services. Failure to make your payment at the time of service can results in an annual finance charge of 25%. Be advised any outstanding balances are due within 28 days of the statement. All balances reaching 30 days past due will be charged the annual finance charge and or be sent to a collection agency. Should your account be sent to a collection agency, you will be financially responsible for all collection fees and legal fees that our office incurs through the process utilized to collect the delinquent balance. If we do not participate in your insurance plan you are responsible for full payment at the time of service.**

New Born Billing Policy

Newborns are usually covered on your insurance plan under a newborn allowance for the first 30 days from date of birth. It is your responsibility to notify your insurance carrier of your newborn. We will hold the charges for 30 days to allow your insurance carrier to enroll your newborn. If we do not receive the new insurance information within the 30 days, we will have to bill you as a self pay patient and you will be responsible for all services rendered.

Cancellation/No Show Policy

We understand there will be times when a scheduled appointment cannot be kept. If you need to cancel or reschedule an appointment, we request that you notify our office 24 hours in advance. If your appointment is made for 'same day" and you find yourself unable to keep it, please call to cancel with a minimum of 3 hours notice in order for another child to be scheduled. Habitual Cancellations/No Shows with failure to provide notice will result in a fee of $25.00, habitual no shows may result in a dismal from practice. IKP reserves the right to dismiss patients who habitual no show for vaccine appointments.

Forms Policy

We understand many organizations such as camps, schools, sports teams require a form to be completed by your pediatrician. It may be necessary for you to drop off the form and it will take our office 48 hours to process your request. There is a form fee range of $5 to$ 20 for processing forms.

Returned Checks

Checks returned to us by the bank will be assessed a $25 returned check fee, in addition to the original amount of the check. You will have 10 days to clear up the outstanding check. If you do not pay the check plus the return fee in the specified time, the check will be sent to a collection agency. In addition, we will only accept cash or credit card for any future visits.

Medical Records

A fee of $5.00 due prior to the release of records.

I have read and fully understand the financial policies of Island Kids Pediatrics and agree to the terms. I also understand that the terms of these financial policies may be amended by the Practice at any time without prior notification.

_____ _____ _____

Signature of Parent/Guardian/Personal Representative **Printed** Name of Parent/Guardian/Personal Representative Date:

Authorization For Medical Treatment of Minors for Island Kids Pediatrics

I, _____, parent or legal guardian of the child/children listed on Page 1, hereby authorize the following individual (s) (must be over the age of 18) to schedule appointments and/or accompany my children to medical appointments. Please list anyone other than the child(ren)'s biological mother or biological father who may be accompanying the child(ren) to appointments. This may include siblings over the age of 18, babysitters, step parents, grandparents, neighbors, friends of the family, etc… I understand that only my child(ren)'s biological mother and father *and* those listed below will have the authority to authorize treatment. I also authorize treatment (except for immunizations) of my teen age 16 and above, in my absence. Authorized individuals include (please print name and relationship):

1._____ 2._____

Please inform the above listed individuals to bring photo identification to appointments. Unlisted individuals may obtain treatment for your child(ren) in the case of an emergency. In that case, an attempt to contact you by phone will be made. This authorization will remain in effect until those designated above have their consent revoked in writing. I have read all of the information above and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify the practice of any changes in my health status, my child(ren)'s health status, or the above information. It is the policy of this office that the adult presenting the child for treatment is responsible for payment of the patient portion at the time of service.

_____ _____ _____

Signature of Parent/Guardian/Personal Representative **Printed** Name of Parent/Guardian/Personal Representative **Date:**

Privacy Statement Acknowledgement

I acknowledge Island Kids Pediatrics has provided its Notice of Privacy Practices, either posted or an individual copy, which provides a detailed description of the uses and disclosures allowed regarding my child's protected health information. If I desire, a copy of the Notice of Privacy Practices is available for me to keep. If revisions are made, I understand that it is my responsibility to request a revised copy. (See date on posted copies)

_____ _____ _____

Signature of Parent/Guardian/Personal Representative **Printed** Name of Parent/Guardian/Personal Representative **Date:**

Communication Authorization to Leave Messages on Voice Mail & Send Email & Txt Messaging

At Island Kids Pediatrics our email policy is to only utilize email/ text messaging communication for appointment reminders, appointment recalls, billing and insurance questions and marketing announcements regarding our practice. My signature below indicates that I agree to this email communication policy and have provided my email address. I authorize reminder calls and other types of detailed messages to be left on my voice mail and/or answering machine. This authorization can only be revoked in writing. Please check a box, sign and date.

☐ I **DO** give a Communication Authorization by signing below: ☐ I **DO NOT** give a Communication Authorization by signing below:

_____ _____ _____

Signature of Parent/Guardian/Personal Representative **Printed** Name of Parent/Guardian/Personal Representative **Date:**

I hereby authorize payment of insurance benefits directly to **Island Kids Pediatrics**. I understand that I am financially responsible for all charges, whether or not paid by insurance, for all services rendered on my behalf or my dependents. I authorize the above noted provider of services in this office to release any information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I understand that my insurance coverage is a contract between myself and my insurance company and I take full responsibility for financial obligations incurred. I authorize the performance of whatever procedures necessary in executing the treatment of the above named patient(s).

I authorize medical care and accept the financial responsibility for my children, my step children, and/or the child(ren) that I am accompanying. I am responsible for all fees and will assure the charges are paid in a reasonable time.

I authorize the release of any medical or other information necessary to process any claims.

I have read and fully understand the financial policies of Island Kids Pediatrics and agree to the terms. I also understand that the terms of these financial policies may be amended by the Practice at any time without prior notification.

_____ _____ _____

Signature: Parent/Guardian/Personal Representative **Print:** Parent/Guardian/Personal Representative **Date:**