(PLEASE LIST ALL CHILDREN CURRENTLY BEING SEEN)

PATIENT REGISTRATION FORM

(Please Print)

Patient Name _____ DOB _____ M/F___

Patient Name _____ DOB _____ M/F___

Patient Name _____ DOB _____ M/F___

Patient Name _____ DOB _____ M/F___

FATHER'S INFORMATION

Father's last name:	First Name:	Birthdate:	Social Security #:
Does the child/children reside at this address? ☐ Yes ☐ No	**Address**	**City**	**State** **Zip:**
Home Phone #: Is this the Primary # ☐ Yes ☐ No ( )	**Cell** Phone # Is this the Primary # ☐ Yes ☐ No ( )	Marital Status: S M D W	
Employer:	Occupation:	Email:	

MOTHER'S INFORMATION

Mother's last name:	First Name:	Birthdate:	Social Security #:
Does the child/children reside at this address? ☐ Yes ☐ No	**Address**	**City**	**State** **Zip:**
Home Phone #: Is this the Primary # ☐ Yes ☐ No ( )	**Cell** Phone # Is this the Primary # ☐ Yes ☐ No ( )	Marital Status: S M D W	
Employer:	Occupation:	Email:	

INSURANCE INFORMATION

Please give Insurance Card(s) to Front Desk Personnel

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Name of Primary Insurance:	Policy #	Group #	Effective Date:
Policy holder of **Primary Insurance**:	Claims Address:		
Name of Secondary Insurance:	Policy #	Group #	Effective Date:
Policy holder of **Secondary Insurance**:	Claims Address:		
Pharmacy Name	**Pharmacy Phone #**	**Pharmacy Address**	

EMERGENCY CONTACT INFORMATION

Name of friend/relative (not living at the same address)	Relationship to Patient	Work Phone No:	Cell phone No:

CONSENT & HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

Please sign below that an opportunity to review a copy of our HIPAA notice for all children listed has been made available for you upon request and found on our website at www.georgetownpediatrics.com. You are entitled to a copy of the notice at any time to keep for your records. This is also a consent that I understand the information I have given is correct to the best of my knowledge and will be held in the strictest of confidence. I understand it is my responsibility to inform this office of any changes in my child/children's status.

Signature: _____ **Date:** _____

CANCELLATION & NO SHOW POLICY

Our requested cancellation policy is a 24 hour notice for well child checkup visits and consultations. A $50.00 fee will be assessed per child for any missed or cancelled appointment without 24 hour notice. Any sick visit appointment not kept will also be assessed a $50.00 missed appointment fee. Your cancellation must be made during regular office hours. As always, emergencies and unforeseen circumstances are taken into consideration. By signing below I am aware and understand the policy.

Signature: _____ ***Date:*** _____

(PLEASE COMPLETE ALL SECTIONS OF ALL FORMS)

(PLEASE LIST ALL CHILDREN CURRENTLY BEING SEEN)

Georgetown Pediatrics' Policies & Fees

Georgetown Pediatrics, PC is committed to providing your child with the best possible medical care. It is our belief that an informed patient is a more satisfied patient; consequently, we are providing the following information to avoid any misunderstanding or disagreement about payment and policies for our professional services.

Co-Pays: Payments are to be paid at the time of service. This includes co-pay and/or any deductible amount at each visit. We will not bill for co-pays. If co-pay payment is not made same day and is billed an **additional $25.00** fee will be added to the account.

Insurance: We participate contractually with a number of insurance companies. If we participate with your child's insurance company; as a courtesy, we will file any claims made for your visit. It is your responsibility to bring your insurance card and photo identification to every visit. It is also your responsibility to be familiar with your insurance plan.

If your child is a visitor to our practice, has no insurance, a participant in a plan we do not accept or participate with, or we are unable to verify your insurance is effective, you will be responsible for **payment in full at the time of service** and will be considered a "Private Pay" patient. We offer a prompt payment discount to "Private Pay" patients if the charges are paid at the time of service and no insurance is to be filed. In the event we cannot verify your insurance, you will be responsible for payment in full at the time of services or you may choose to reschedule.

If your child is covered by a HMO or POS plan and we are not listed as your primary care provider, we will see your child, but you will be considered "Private Pay" and required to pay for services as they are rendered until Primary Care Provider is correct.

If you are scheduled for a Well Child Exam, and other Health concerns are brought up that would typically require a sick visit, your insurance may consider these two separate visits and assess a co-pay. Co-pay and other charges will be billed accordingly.

If your child has been prescribed an inhaled medication we are required to teach the proper use of the inhaler so that your child receives the full benefit of the medication. There may be an additional charge for this.

Please know that we have correctly performed & documented the services as required by the CPT coding guidelines for all services provided during your visit. Procedures performed in office are listed as "surgery" by all insurance providers & cost cannot be determined by your physician. All in office procedures are subject to your insurance coverage & deductible.

Should any discrepancy occur regarding your understanding of benefits and coverage, it is your responsibility to resolve such matters with your insurance company. You are financially responsible for any amount not covered by your child's plan, and all charges incurred in your child's care and treatment. Georgetown Pediatrics, P.C. will expect payment from you as indicated by your insurance carrier. Please remember that your insurance is a contract between you and the insurance company, not the doctor.

Payment Arrangements: If you are unable to pay your balance in full from the statement date, please contact our office immediately for a written and signed payment plan. Failure to do so may result in additional finance charges being applied to your account. If you fail to make payment in full for services rendered in a timely manner, your outstanding balance will be sent to an outside collections agency. You will be responsible for any fees associated with the collection of your balance. Failure to meet your financial responsibility with our practice may lead to dismissal from the practice.

Methods of Payment: We accept cash, checks, Visa, MasterCard, American Express, Discover and Debit Cards.

Divorce, Separation or Blended Family: At Georgetown Pediatrics, PC, we understand that issues related to divorce are very difficult for the entire family. However, we will not be party to custodial, separation or financial disputes relating to individuals with regard to minor children to whom services are provided. All copays, co-insurance, and deductibles will be collected at the time of service from the individual accompanying the child at the visit. Both parents have access to the minor child's medical record unless we are provided with a copy of a court order that mandates otherwise. We maintain that divorce, separation, and custody agreements should not enter into the medical care of a child; such matters should remain between the parents.

Annual Administrative Fee (effective 6/1/2013) Our office finds it necessary to collect an annual Administrative Services Fee (ASF). The ASF will be $20.00 for one child or $30.00 per family. These administrative fees are intended to cover the cost of certain administrative services we provide that are not covered by your insurance. Such as, after hours calls to CHOA (these calls are charged to our practice), completion of all forms including, FMLA, disability forms, physical forms, school forms, patient requested generated reports, such as claims, statements, payment histories as well as pharmacy preauthorization's and insurance pre-certification's. **If the ASF is not paid annually, you understand that you may be billed on a per item basis.**

I have read, fully understand, and agree to abide by the above consent for medical treatment, financial responsibilities, release of medical information, fees and insurance authorization for child/children listed below.

Name: _____ DOB _____ Name: _____ DOB _____

Name: _____ DOB _____ Name: _____ DOB _____

Parent/Guardian Signature: _____ Date: _____

(PLEASE COMPLETE ALL SECTIONS OF ALL FORMS)