

The Best Kids Patient Registration Form

This form must be completed before we can treat your child.

Newsletter and updates will be sent by E-mail only. Copies will be available through our Web site.

Date: _____

E-mail Address: _____ Account No.: _____

1st Patient's Full Name: _____ "Nickname": _____
Birth Date: _____ SSN: _____ Sex: _____ OB Doctor: _____

2nd Patient's Full Name: _____ "Nickname": _____
Birth Date: _____ SSN: _____ Sex: _____ OB Doctor: _____

3rd Patient's Full Name: _____ "Nickname": _____
Birth Date: _____ SSN: _____ Sex: _____ OB Doctor: _____

If necessary, please print another copy of this form and fill it out for additional children.

Father's Name: _____ Home Phone: _____
Cell Phone: _____ DOB: _____ SSN: _____
Address: _____
No. and Street City State Zip

Father's Employment: _____ Work Phone: _____

Mother's Name: _____ Home Phone: _____
Cell Phone: _____ DOB: _____ SSN: _____
Address: _____
No. and Street City State Zip

Mother's Employment: _____ Work Phone: _____

Stepfather/Mother's Name: _____ SSN: _____
Home Phone: _____ Cell Phone: _____ DOB: _____
Stepfather/Mother's Address: _____
No. and Street City State Zip

Stepfather/Mother's Employment: _____ Work Phone: _____

Legal Custodian's Name: _____ Home Phone: _____
Cell Phone: _____ DOB: _____ SSN: _____
Custodian's Address: _____
No. and Street City State Zip

Custodian's Employment: _____ Work Phone: _____

Emergency Contacts

(Please list TWO who live outside your home.)

1st Contact Name _____ Relation: _____
Home Phone: _____ Cell Phone: _____
Address: _____
No. and Street City State Zip

2nd Contact Name _____ Relation: _____
Home Phone: _____ Cell Phone: _____
Address: _____
No. and Street City State Zip

Insurance Information:

Primary Insurance: _____
Subscriber's Name: _____ SSN: _____
DOB: _____ Policy ID No: _____ Group No: _____

Secondary Insurance: _____
Subscriber's Name: _____ SSN: _____
DOB: _____ Policy ID No: _____ Group No: _____

Patient Financial Responsibilities:

It is your responsibility to give our office current and up-to-date information. This includes any changes in name(s), address(s) and telephone number(s), as well as new insurance information.

It is your responsibility to know your insurance plan's policies and guidelines. Every insurance company is different. You should know if your insurance plan's company has a preferred lab or hospital that we are required to use in order for your service to be covered.

It is your responsibility to contact your insurance company to verify that our physician is a participating physician with your insurance company and with your specific plan.

Are well checks covered? ____ Yes ____ No.
Are immunizations covered? ____ Yes ____ No.

Save all the Explanations of Benefits (EOB) forms you receive from your insurance companies. These EOB forms allow you to know why your insurance company has paid as they did. An EOB form can serve as the basis for an appeal. It will allow us to help you negotiate with your insurance company. Please study these forms closely. They are important.

Collection Policies:

After your insurance pays its portion, the remaining balance becomes your responsibility. You will receive 2 monthly statements. If you fail to pay your bill in full or make payment arrangements with us by the date listed on the second statement, your account will then be placed in our collections department. If we do not hear from you, your account will be sent to an outside collection agency. We do accept Visa and MasterCard. Please note that our extended limit for patient due is \$200.00 on an account. We cannot exceed this amount and need for all accounts to be kept current.

1. I authorize The Best Kids to initiate and maintain all medical/surgical treatment of my child/children in an emergency or life threatening situation until proper notification can be given and consent obtained.
2. **RELEASE OF INFORMATION** – I authorize release of any medical information necessary to file any claims to my insurance carrier. This signature or photocopy thereof irrevocably authorizes the release of information necessary to process an insurance claim and further authorizes payment of medical benefits to the physician providing services. ***In order to assist you with your insurance company, our office will be glad to submit your claim to your insurance company for you.***
3. I understand that payment is due at the time services are rendered. This includes those times when you have not met your deductible, or if you are a self-pay or have an 80/20 type plan and are responsible for a portion of your bill. Copays are paid when you sign in. Delinquent accounts, i.e., accounts with balances due greater than 60 days, will be subject to an interest fee at a monthly periodic rate of 1.5% (equal to an annual percentage rate of 18%).
4. Read and understand Notice of Privacy Practice Acknowledgment.

I, _____ (the Patient, Parent or Legal Guardian)
have read/received a copy of The Best Kids Notice of Privacy Practices.

PARENT/LEGAL GUARDIAN SIGNATURE SSN: _____

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