GVOZDEN PEDIATRICS, PA

Today's date: ________________ **New/ Change/Update**

PATIENT REGISTRATION (please print legibly and fill out all fields) **Address/Insurance/Both**

Patient name: (First) ____________________ Middle_____________ Last_________________ Sex M /F

Billing address: ________________________________ City___________________ State_____ Zip_____

Date of Birth_____/______/_____

Brothers & Sisters

Name________________ DOB_______ Name________________ DOB_______ Name___________________ DOB_________

Parent # 1 (Circle) MOM /DAD

Name (First) ________________________(MI) _____ Last_____________________________________

Address (if different than patient) ____

Social Security #____________________DOB________/_____/_________

Cell Number___________________________ Work Number___________________________________

Employer Name____________________________________ Occupation__________________________

Email Address____

Parent # 2 (circle) MOM /DAD

Name (first) _____________________ (MI) ________ Last_____________________________________

Address (if different than patient) ____

Social Security Number____________________ DOB___________/__________/_____________

Cell Number______________________________ Work Number________________________________

Email Address____

Employer Name___________________________________ Occupation___________________________

(SEE OTHER SIDE)

Primary contact for Confirmation Calls, Billing etc. (Circle one) MOM/DAD

Policy Holder (circle) MOM /DAD

CONSENT AND AUTHORIZATION AGREEMENT

Consent or treatment:

I understand that medical treatment and examination is/or may become necessary for the patient by a health care provider. I hereby consent to and authorize the administration of all diagnostic and therapeutic treatments that may be considered advisable or necessary in the event of an emergency.

Assignment of Benefits:

For patients with accepted insurance, I hereby authorize my insurance benefits to be paid directly to the provider. I am responsible for non-covered services.

Release of Information:

I hereby authorize the release of any medical information by the provider necessary to process claim forms or to aid in medical testing and treatment.

Agreement to pay services:

I understand and agree that I am responsible to pay the charges for all services rendered by the patient on this registration.

If this account is turned over to a third party, I will be held accountable for all collection fees, attorneys' fees and court costs.

Fees:

I understand that fees will be assessed for the following:

- Credit card payment on balances (3%)
- Returned Checks
- Failure to show up for any scheduled appointments
- Failure to provide at least 24-hours' notice when cancelling any scheduled appointments
- Billing of copays that are due at the time of service
- Claims resubmission

Notice of privacy practices written acknowledgement form

- I have been notified of GVOZDEN PEDIATRICS, P.A. Notice of Privacy Practices

I have read the above statements; understand and agree them.

(Parent or Guardian must sign if patient is a minor)

Print name_________________________________ Relationship to patient _______________

Signature__________________________________ Date_________/__________/________