GVOZDEN PEDIATRICS, PA

Today's date: _____

PATIENT REGISTRATION (please print legibly and fill out all fields)

Patient name: (First) _____ Middle_____ Last_____ Sex M /F

Billing address: _____ City_____ State_____ Zip_____

Date of Birth_____/_____/_____

Cell Number_____

Email Address_____

Only fill out if subject/child is a minor—under 18 years of age

(Circle) MOM /DAD

Name of parent: _____Cell number _____

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_____/_____/_____