

PEDIATRIC REGISTRATION FORM

BRICKYARD PEDIATRICS

219-940-9605 (PHONE) | 219-940-9606 (FAX) | WWW.BRICKYARDPEDS.COM

CHILD'S INFORMATION - SEPARATE FORMS MUST BE COMPLETED FOR EACH CHILD IN A FAMILY

CHILD'S FULL NAME (FIRST MIDDLE LAST)			CHILD'S GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	CHILD'S PRIMARY LANGUAGE <input type="checkbox"/> ENGLISH <input type="checkbox"/> SPANISH <input type="checkbox"/> OTHER _____	CHILD'S DATE OF BIRTH
PRIMARY HOME ADDRESS (NO P.O. BOXES)			FAMILY'S PRIMARY EMAIL ADDRESS		
CITY	STATE	ZIP	CHILD'S ETHNICITY <input type="checkbox"/> HISPANIC <input type="checkbox"/> NON-HISPANIC	<input type="checkbox"/> DECLINE	CHILD'S RACE <input type="checkbox"/> AMERICAN INDIAN OR ALASKAN NATIVE <input type="checkbox"/> ASIAN <input type="checkbox"/> BLACK OR AFRICAN AMERICAN <input type="checkbox"/> NATIVE HAWAIIAN OR PACIFIC ISLANDER <input type="checkbox"/> WHITE <input type="checkbox"/> OTHER _____
PRIMARY HOME PHONE	PRIMARY CELL PHONE		PRIMARY WORK PHONE		

MOTHER or LEGAL GUARDIAN'S INFORMATION

FATHER or OTHER LEGAL GUARDIAN'S INFORMATION

MOTHER/GUARDIAN'S FULL NAME			FATHER/GUARDIAN'S FULL NAME		
MOTHER/GUARDIAN'S SOCIAL SECURITY #	MOTHER'S MAIDEN NAME OR GUARDIAN'S RELATION TO THE PATIENT (IF APPLICABLE)		FATHER/GUARDIAN'S SOCIAL SECURITY #	CHILD LIVES WITH (CHECK ONE) <input type="checkbox"/> MOTHER <input type="checkbox"/> FATHER <input type="checkbox"/> BOTH <input type="checkbox"/> OTHER _____	
MOTHER/GUARDIAN'S DATE OF BIRTH	MOTHER/GUARDIAN'S MARITAL STATUS <input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE <input type="checkbox"/> SEPERATED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED		FATHER/GUARDIAN'S DATE OF BIRTH	FATHER/GUARDIAN'S MARITAL STATUS <input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE <input type="checkbox"/> SEPERATED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED	
MOTHER/GUARDIAN'S MAILING ADDRESS <input type="checkbox"/> (CHECK IF SAME AS CHILD)			FATHER/GUARDIAN'S MAILING ADDRESS <input type="checkbox"/> (CHECK IF SAME AS CHILD)		
CITY	STATE	ZIP	CITY	STATE	ZIP
MOTHER/GUARDIAN'S HOME PHONE	MOTHER/GUARDIAN'S CELL PHONE		FATHER/GUARDIAN'S HOME PHONE	FATHER/GUARDIAN'S CELL PHONE	
MOTHER/GUARDIAN'S EMPLOYER	MOTHER/GUARDIAN'S WORK PHONE		FATHER/GUARDIAN'S EMPLOYER	FATHER/GUARDIAN'S WORK PHONE	
MOTHER/GUARDIAN'S EMAIL ADDRESS			FATHER/GUARDIAN'S EMAIL ADDRESS		

INSURANCE INFORMATION - THIS SECTION MUST BE COMPLETE OR PAYMENT IN FULL IS DUE AT TIME OF SERVICE

PRIMARY INSURANCE COMPANY NAME	SUBSCRIBER'S NAME	SUBSCRIBER'S DATE OF BIRTH	PATIENT'S RELATIONSHIP TO SUBSCRIBER <input type="checkbox"/> CHILD <input type="checkbox"/> SELF <input type="checkbox"/> OTHER _____
SECONDARY INSURANCE COMPANY NAME	SUBSCRIBER'S NAME	SUBSCRIBER'S DATE OF BIRTH	PATIENT'S RELATIONSHIP TO SUBSCRIBER <input type="checkbox"/> CHILD <input type="checkbox"/> SELF <input type="checkbox"/> OTHER _____

EMERGENCY CONTACT INFORMATION

Every effort is made to protect our patients' privacy. However, in the case of an emergency in which a parent/legal guardian cannot be reached, we may need to call someone on your child's behalf. Please list below the name of someone your child does not live with and who we have your permission to contact if necessary.

NAME OF PERSON NOT LIVING WITH YOUR CHILD	RELATIONSHIP TO CHILD	EMERGENCY CONTACT'S PHONE NUMBER
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PREFERRED PHARMACY

NAME OF PHARMACY	ADDRESS OR INTERSECTION	PHONE (IF KNOWN)	FAX (IF KNOWN)
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PLEASE CONTINUE ON THE BACK

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FINANCIAL POLICY & CONSENT FOR TREATMENT

Financial Policy

By signing below, you accept financial responsibility for all services rendered on your child's behalf whether or not you are present on the date of service. Please note that a divorce decree, separation agreement, or any other financial arrangement between two parties does not release your financial obligation to the patient's account. Although another guardian or adult may provide health insurance for the patient, you are still responsible for all remaining balances.

- We file claims to participating insurance companies as a courtesy to you - you are and remain responsible for ensuring full payment. We will bill your insurance company only if we are in network and only if your insurer accepts claims electronically. You are responsible for confirming our network status with your insurance plan prior to scheduling an appointment. Patients are considered self-pay for services covered by worker's comp or auto insurance.
- If we do not receive payment from your insurance company within 60 days from the date of service, then you will be billed for the balance in full. We will not file claims more than 90 days after the date of service and you must pay the outstanding balance in full.
- Patients with an outstanding balance of 90 days or more must arrange an acceptable payment plan or their account will be turned over to a collection agency and they will be dismissed from the practice. Payment plans are available for patients with financial difficulty; however, it is your responsibility to contact our billing specialist to request assistance before your account becomes delinquent.
- Occasionally during scheduled well child visits a physician will diagnose and treat a problem. When appropriate, problems addressed during preventative exams will be billed as routine care in addition to the well child visit. Some insurance policies do not cover both services. In the event that you schedule a well child visit and a problem is addressed, you may be responsible for an additional co-pay, co-insurance, deductible, or denial after the visit.
- We are required by law to accurately report all services received by our patients. Not all insurance plans cover all services we provide. It is your responsibility to know if you have coverage before services are rendered. In the event that your insurer determines a service is "not covered" under your policy, we cannot change the procedure or diagnosis codes in order for it to be paid.
- All co-pays are due at the time of service regardless of who brings the child in for the appointment.
- When paying with a personal check, a valid photo ID of the check signer is required. Only checks that have been printed with the check signer's name and address will be accepted. All returned checks are assessed a \$25.00 service charge. Failing to remit payment within 45 days is grounds for dismissal from the practice.
- If you must cancel or reschedule your appointment(s), please notify us at least 24 hours in advance. Same day cancellations will be limited. Repeated same day cancellations are the same as a no-show. If you are more than 10 minutes late for your appointment we will try to accommodate you but we reserve the right to reschedule. A \$25 fee will be charged for no-show appointments. Patients, not Insurance, are responsible for paying this fee and will be notified on the second offence. Repeated violations may result in administrative action and/or possible termination from the practice.

Consent for Treatment

As the parent or legal guardian of the patient listed below, I do hereby consent to the performance of routine diagnostic procedures and/or medical treatment as deemed necessary or advisable by my child's physician(s) at Brickyard Pediatrics. I hereby authorize Brickyard Pediatrics to apply for benefits on my child's behalf for all services rendered. I certify that the information I have provided regarding my child's insurance coverage is correct. I further authorize the release of any and all information necessary for my child's insurance company to determine benefits for services rendered. I request payment of authorized benefits be made payable to Brickyard Pediatrics on my child's behalf. I have read and agree to the financial policies stated above. I understand that I am ultimately responsible for the balance on my child's account for all services rendered.

Parent/Guardian's Name & Signature

Child's Name

Print Parent/Guardian's Full Name

Print Child's Name

Date of Birth

Parent/Guardian's Signature

Date of Signature

AUTHORIZED INDIVIDUALS ALLOWED TO ACCOMPANY MY CHILD FOR MEDICAL CARE AND RECEIVE MEDICAL RESULTS

Please list anyone who has your permission to bring your child to our office for medical care in your absence and/or who is authorized to receive your child's medical information. In the event of an emergency, only people you authorize in writing, per HIPAA requirements, will be able to accompany your child for treatment without you being present.

NAME OF AUTHORIZED INDIVIDUAL (Last, First, Middle Initial)	DATE OF BIRTH	RELATIONSHIP TO CHILD	PRIMARY PHONE
NAME OF AUTHORIZED INDIVIDUAL (Last, First, Middle Initial)	DATE OF BIRTH	RELATIONSHIP TO CHILD	PRIMARY PHONE