ACADEMY PARK PEDIATRICS REGISTRATION FORM **Please complete entire form**

Date:_____ (Expires every 12 months or if changes occur)

Patient's Name:_____SS#_____Male/Female DOB_____

Patient's Name:_____SS#_____Male/Female DOB_____

Patient's Name:_____SS#_____Male/Female DOB_____

(Please list all children in household)

Mother's Information: Name_____SS#_____

Address:_____/_____/____/_____Date of Birth_____

City State Zip

Primary Phone_____ Work Phone_____

Email address_____

Father's Information: Name_____SS#_____

Address:_____/_____/____/_____Date of Birth_____

City State Zip

Primary Phone_____ Work Phone_____

Email address_____

Step Parent (s) (If applicable)_____

Separate form required for adult other than Mother/Father/legal guardian to accompany patient under 18 years of age to appointments – ask receptionist for a blank form please

Financially Responsible Party:_____SS#_____

Relationship to patient_____

Emergency Contact_____Relationship_____Phone_____

Other than parent

Primary Insurance _____ID#_____

Group#_____Policy Holder:_____

Policyholder relationship to patient:_____Date of Birth_____

Secondary Insurance_____ID#_____

Group#_____Policy Holder:_____

Policy holder relationship to patient:_____Date of Birth_____

VFC vaccine program available for uninsured, pre approved Medicaid, or American Indian/Alaska Native

I authorize Academy Park Pediatrics to fax health forms to my child's school, camp, and/or daycare center.

BILLING POLICY

*Copayment/Self Pay due at time of service. Non payment may require postponement of well care appt.

*Balances due may carry a $6/month rebilling charge payable by parent, guardian, responsible party.

*Well Care appts. missed or not cancelled 24 hours in advance may be charged $25 fee per child.

*Patients must be PRE APPROVED for Medicaid or CHP+. If pre approval is not obtained, no past, current or future charges will be billable to Medicaid/CHP+. Medical services will need to be provided elsewhere by an open practice.

I accept responsibility for any unpaid services or services not covered by insurance. Should it become necessary to forward my account for professional collection, in addition to the amount owed, I will also be responsible for reasonable costs of collection, including attorney fees.

SEE HIPAA AND FINANCIAL AGREEMENT for expanded information

SIGNED_____Relationship to patient_____

Signature of patient if over 18 years of age_____