SUNSHINE PEDIATRICS

ALL AREAS MUST BE COMPLETED: **PATIENT REGISTRATION**

Patient's Full Name: _____ Nick Name: _____

Date of Birth: _____ SSN: _____ Age: _____ Sex: ☐ Male ☐ Female

Patient's Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: [*primary*] _____ Phone: [*secondary*] _____

Mother: _____ Father: _____

SSN: _____ DOB: _____ SSN: _____ DOB: _____

Address: [*if different*] _____ Address: [*if different*] _____

Cell Phone: _____ Cell Phone: _____

Work Phone: _____ Work Phone: _____

E-mail: _____ E-mail: _____

Emergency Contact Name: _____ Emergency Contact Relationship: _____

Home Phone: _____ Work Phone: _____ Other Phone: _____

PRIMARY INSURANCE INFORMATION

Primary Insurance Company: _____ Patient ID: _____

Group Number: _____ Policy Holder: _____ Sex: ☐ Male ☐ Female

Relationship to patient: _____ Policy Holder's SSN: _____

Policy Holder's Date of Birth: _____

SECONDARY INSURANCE INFORMATION

Secondary Insurance Company: _____ Patient ID: _____

Group Number: _____ Policy Holder: _____ Sex: ☐ Male ☐ Female

Relationship to patient: _____ Policy Holder's SSN: _____

Policy Holder's Date of Birth: _____

PLEASE PROVIDE THE NAME OF EACH PERSON WHO IS ALLOWED TO ACCESS MEDICAL RECORDS, ALLOWED TO BRING THIS PATIENT FOR MEDICAL CARE AND TO WHOM WE MAY SPEAK REGARDING THE PATIENT'S HEALTH.

Name: _____ Relationship to patient: _____ Phone: _____

Name: _____ Relationship to patient: _____ Phone: _____

Name: _____ Relationship to patient: _____ Phone: _____

My signature below acknowledges I have read and agree to all of the following: A FEE OF **$25.00** WILL BE CHARGED FOR ANY APPOINTMENT THAT IS MISSED AND NOT CANCELLED BEFORE THE APPOINTMENT TIME, INSURANCE **WILL NOT PAY THIS FEE!** After missing 3 appointments you will be discharged from the practice. At which time you will have 30 days to find a new physician outside of Sunshine Pediatrics. Appointments: Sick - within 48 hours*; Well - within 90 days*; Urgent - triage*. If you are 15 minutes (or more) late for a scheduled appointments, you will be rescheduled. Please note that when requesting copies of medical records, immunization records, prescriptions or refills will require (72) seventy-two hours notice. I acknowledge that I have read the Notice of Privacy practices displayed in the office (I may request a copy at any time) for the above named practice and that I am the legal guardian for the above named patient. I herby consent to today's visit and all subsequent visits to admission and treatment by Sunshine Pediatrics staff. It is the responsibility of the guardian to provide and maintain active insurance coverage; otherwise all charges incurred will be the guardian's responsibility. Co-Pays and payments for services are due at the time services are rendered. This assignment will remain in effect until revoked by me in writing. This document can, and if necessary, will be used in a court of law. A photocopy of this agreement is considered as valid as an original. **If fees are incurred in order to collect any delinquent accounts, those fees will be the responsibility of the guardian. I understand that I am financially responsible for all charges whether or not paid by insurance, SPECIFICALLY TELEPHONE CONSULTATIONS, PRESCRIPTIONS, Completion of forms, AND AFTER HOURS VISITS.** I hereby assign all medical and/or surgical benefits, to include medical major benefits to which the patient is entitled, private insurance and any other health plan to **SUNSHINE PEDIATRICS**. I hereby authorize assignee to release all information necessary to secure the payment.

Signature: _____ Print Name: _____ Date: _____

If fees are incurred in order to collect any delinquent accounts those fees will be the responsibility of the patient/ guarantor.

I hereby apply and consent to today's visit and all subsequent visits to Admission and Treatment by Sunshine Pediatrics staff and authorize all routine office procedures and services, treatment, examination, and diagnostic procedures, including but not limited to laboratory testing, drugs, or procedures as well as release of medical data and/or copies to other agencies and/or physicians. I may be referred to for follow-up care as may be ordered by the Doctor. I also certify that no guarantees or assurances have been made as to the results that may be obtained. I hereby authorize Sunshine Pediatrics to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such care to third party payors, health practitioners, and organizations.

I authorize and request that my insurance company assign payment directly to Sunshine Pediatrics for services rendered to my dependent. I understand that I am responsible for all charges regardless of insurance coverage. I understand that it is my responsibility to verify covered benefits with my carrier, obtained proper referrals, and pay the treating physician deductible co-payment and co-insurance amounts.

I give consent for my son/daughter to under go examination and treatment by Sunshine Pediatrics.

I understand my signature requests payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of HFCA: 1500 claim form is completed, (secondary insurance box), my signature authorizes releasing of the information to the agency above.

Signature of Guardian: _____ **Date:** _____

Patients of SUNSHINE PEDIATRICS

Due to our contractual agreements with insurance companies and State Law, all co-pays **MUST** be collected at the time of service.

All deductibles **must** also be collected after filing with your insurance. (All deductibles will be collected at the time of service if we are not a participating provider with your insurance company)

Failure to pay the designated co-pay amount set by your insurance company will result in an additional charge. We will be enforcing a non-payment of co-pay fee. This fee will be an additional charge added to your total for those particular day's charges. This fee does not waive your co-payment.

Sunshine Pediatrics does not participate in legal issues i.e. divorce, accidents or other legal issues all payments are expected in full at the time of service from the Guardian or approved person bringing the patient to Sunshine Pediatrics.

Fees are as follows:

Non-Payment of Co-Pay $10.00
Returned Check Fee $45.00 (your method of payment will then be cash/credit or debit only)
No Show Appointment Fee 1st Offense $25.00
2nd Offense $50.00
3rd Offense Dismissal
No appointments will be scheduled until fees are paid in full.
Year end detailed receipts for taxes $3.00 per patient
Copy of Medical Records $1.00 a page 1-25
$0.50 a page 26-50
$0.25 a page 51-75
No charge 75+ pages
Completion of All Paperwork* (FMLA, AFLAC, Disability, etc)$25.00

All Copies and Paperwork will be completed 10-14 business days from the time a signed request is received.

Signature of Guardian: _____ **Date:** _____