PEDIATRIC REGISTRATION FORM

Youthcare Pediatrics
(Phone) 478-923-3360 | Fax 478-923-9977
www.youthcare.net

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

CHILD'S FULL NAME (FIRST MIDDLE LAST)	CHILD'S GENDER ☐ MALE ☐ FEMALE	CHILD'S PRIMARY LANGUAGE ☐ ENGLISH ☐ OTHER: ☐ SPANISH _____	CHILD'S DATE OF BIRTH

PRIMARY HOME ADDRESS (NO P.O. BOXES)			FAMILY'S PRIMARY EMAIL ADDRESS	
CITY	STATE	ZIP	CHILDS ETHNICITY ☐ HISPANIC ☐ DECLINE ☐ NON-HISPANIC	CHILD'S RACE ☐ DECLINE ☐ ASIAN ☐ AMERICAN INDIAN ☐ BLACK OR AFRICAN AMERICAN ☐ PACIFIC ISLANDER ☐ WHITE ☐ 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 OF GUARDIAN'S RELATION TO PATIENT APPLICABLE		FATHER/GUARDIAN'S SOCIAL SECURITY #	CHILD LIVES WITH (CHECK ONE) ☐ MOTHER ☐ FATHER ☐ BOTH ☐ OTHER:_____	
MOTHER/GUARDIAN'S DATE OF BIRTH	MOTHER/GUARDIAN'S MARITAL STATUS ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPERATED ☐ SINGLE		FATHER/GUARDIAN'S DATE OF BIRTH	FATHER/GUARDIAN'S MARITAL STATUS ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPERATED ☐ SINGLE	
MOTHER/GUARDIAN'S MAILING ADDRESS			FATHER/GUARDIAN'S MAILING ADDRESS		
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 ☐ CHILD ☐ SELF ☐ OTHER:_____
SECONDARY INSURANCE COMPANY NAME	SUBSCRIBER'S NAME	SUBSCRIBER'S DATE OF BIRTH	PATIENT'S RELATIONSHIP TO SUBSCRIBER ☐ CHILD ☐ SELF ☐ 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 LIS BELOW THE NAME OF SOMEONE YOUR CHILD DOES NOT LIVE WITH AND WHO WE HAVE PERMISSION TO CONTACT IF NECESSARY.

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

PREFERRED PHARMACY

NAME OF PHARMACY	ADDRESS OR INTERSECTION	PHONE (IF KNOWN)	FAX (IF KNOWN)

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FINACIAL 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 divocrce decree, seperation agreement, or any other financial arrangements between two parties does not release your financial obligation to the patient's account. Although another guardian or adult maay 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.
- If we do not receive payment from your insurance company within 60 days from the date of service, then you may be billed for the full 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.
- Patient's 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. Payment plans are available for patientswith 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 addresses 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 any additional co-pay, co-insurance, deductible, or denial after the visit.
- We are required by law to accurately report all services 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 an 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 signer's name and address will be accepted. All returned checks will be assessed a $25.00 service charge. Post dated checks will not be accepted.
- If for any reason you must cancel or reschedule your appointment(s), please notify our office at least 24 hours in advance. Families that no-show 3 times in 12 months may be dismissed from the practice. Two appointment cancellations with less than 24 hours notice is the equivalent of a no-show. If you aremore than 10 minutes late for an appointment we will do our best to accomodate you but we reserve the right to reschedule your appointment.

CONSENT FOR TREATMENT

As the parent or legal guardian listed below, I do hereby consent to the performance of routine diagnostic procedures and/or medical treatemtn as deemed necessary or advisable by my child's physician(s) at Youthcare Pediatrics. I hereby authorize Youthcare Pediatrics of Central Georgia to apply for benefits on my childs 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 an 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 Youthcare Pediatrics on my child's behalf. I have read and agree to the financial policies stated above. I understand that I am ultimately responsible tor 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

Parent/Guardian's Signature

Child's Date of Birth

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 HIPPA requiremnts, will be able to accompany your child for treatment without you being present.

NAME OF AUTHORIZED INDIVIDUAL (FIRST MIDDLE LAST)	DATE OF BIRTH	RELATIONSHIP TO CHILD	PRIMARY PHONE
NAME OF AUTHORIZED INDIVIDUAL (FIRST MIDDLE LAST)	DATE OF BIRTH	RELATIONSHIP TO CHILD	PRIMARY PHONE