CENTER FOR PEDIATRIC MEDICINE **Today's Date:**___/_____/_____

Patient Registration Form

Last name (child):_____ **First name**: _____ **MI**: ____

Sex: _____ **DOB**: _____ **Primary language(s)**:_____

Billing address:_____
(Street address) *(City)* *(State & Zip)*

Primary phone #:_____ **Alternate phone #**:_____

Ethnicity (circle only one): Hispanic or Latino? *Yes / No / Decline to answer*

Race (circle all that apply): *Am.Indian / Asian / Black / Hawaiian or Pacific Islander / White / Decline to answer*

Additional children:

Name:_____**DOB**:_____**Sex**:_____ **Name**:_____**DOB**:_____**Sex**:_____

Name:_____**DOB**:_____**Sex**:_____ **Name**:_____**DOB**:_____**Sex**:_____

Parent #1: **Last name**:_____ **First name**: _____ **DOB**:_____

Primary phone: _____**Work phone**:_____ **Lives w/ patient?:** *Yes / No / Other*

Employer/Occupation: _____ **Relationship to patient**: _____

Parent #2: **Last name**:_____ **First name**: _____ **DOB**:_____

Primary phone: _____ **Work phone**:_____ **Lives w/ patient?:** *Yes / No / Other*

Employer/Occupation:_____ **Relationship to patient: _____**

Parents are: ☐ Married ☐ Living Together ☐ Separated ☐ Divorced (If divorced, who is the Custodial Parent: ☐#1 ☐#2)

☐ Single ☐ Widowed

(*Parent not living with patient address:* ☐#1 ☐#2) _____
(Street address) *(City)* *(State & Zip)*

Primary insurance: _____ **ID#**_____

Policy holder's full name: _____ **DOB**:_____ **Group#**:_____

Secondary insurance: _____ *ID#*_____

Policy holder's full name: _____ *DOB:*_____ *Group#:*_____

Emergency contact (other than parents): *Name*:_____*Phone#*:_____ *Relationship*_____

Preferred contact method (Please select one option below)

Medical issues, appointment reminders, and recalls: ☐ *Primary phone* ☐ *Alternate phone* ☐ *Work phone* ☐ *other:*_____

Primary care provider (Please select a provider):

☐ *Ana Paula Machado, MD* ☐ *Joan Magner, MD* ☐ *Robert Golenbock, MD* ☐ *Claire Bailey, MD* ☐*Dayna Nethercott, PA*

☐ *Lisa Boule, APRN* ☐ *Alpha Journal, PA* ☐ *Janice Kolesar, APRN*

Please select a primary location: ☐ Danbury ☐ New Fairfield

Email address (to access Patient Portal): _____

CENTER FOR PEDIATRIC MEDICINE, P.C.

Financial Policy

The physicians and staff at the Center for Pediatric Medicine are dedicated to providing you with quality health care. Your understanding of our financial policy is an important part of your care and treatment. Please read the following financial policy. If you have any questions, feel free to discuss them with the staff in our Billing Dept. at (203) 798-7661.

YOUR INSURANCE: You, as the responsible party for your child, must furnish our office with up to date insurance information. Any change in your insurance coverage must be reported to our office immediately.

The Center for Pediatric Medicine has contracts with many insurance plans. For these plans we will collect your co-payment at the time of your scheduled appointment. Our Billing Department will submit the claim for these plans on your behalf. In the event your health plan determines services to be "non-covered", you will be responsible for the complete charge. Payment will be due upon receipt of a statement from our office.

If you have an insurance plan that we do not participate in, it is our policy that you pay for the services that you received, in full, at the time of your appointment. We will supply you with the necessary paperwork so that you can submit the claim yourself and be reimbursed by your insurance company.

DEDUCTIBLE: If you have a deductible, HSA or HRA plan, payment is due at the time of service. Your credit/ debit card may be kept on file for your convenience. If you do not want to keep your card on file we will collect 65% of the charge and bill you for the remaining balance after the insurance company processes the claim.

PAST DUE ACCOUNTS: Our Billing Department will review those accounts that are not paid in a responsible or timely manner. These accounts may be referred to an outside collection agency and could influence your credit rating. Any charges assessed by outside agencies in collecting this debt will become your responsibility. If you are having a problem keeping your account up-to-date, please contact our Billing Office at (203) 798-7661. You can make arrangements with us to set up a payment plan to keep your account current.

MISSED APPOINTMENTS: In order to provide the best possible service and availability to all of our patients, you will be charged a fee of $25.00 for failing to call and cancel an appointment 24-hours prior to the scheduled time.

RETURNED CHECKS: A $20.00 charge will be added to your account for any check returned by the bank for insufficient funds.

FORMS: A fee is charged for each form (school, camp, and daycare).

I have read and understand the financial policy of the Center for Pediatric Medicine and I agree to be bound by its terms. I also understand and agree that such terms will remain in force for the duration of my relationship with the Center for Pediatric Medicine and that such terms may be amended from time-to-time by the practice.

I hereby authorize Center for Pediatric Medicine to release to my insurance company any information acquired in the course of my examination and treatment.

_____ _____

Signature of patient or responsible party Date

MEDICAL RECORDS

I consent to the release of my medical records to other medical providers only, as necessary, for completeness of my child's treatment. Release of medical data includes disclosure of medical information obtained from other healthcare professionals in accordance with your wishes.

_____ _____

Signature of patient or responsible party Date

Your child's name:_____ D.O.B._____

CENTER FOR PEDIATRIC MEDICINE **Today's Date:____/_____/_____**