

REGISTRATION FORM:

DATE: _____

PARENT RESPONSIBLE FOR BILL

NAME _____ HOME PHONE _____
(LAST) (FIRST) (MIDDLE)

ADDRESS _____ CELL PHONE _____

CITY _____ ST. _____ ZIP _____ WORK PHONE _____

E-MAIL ADDRESS _____ DATE OF BIRTH _____ SEX _____

SOCIAL SECURITY # _____ RELATIONSHIP TO PATIENT _____

EMPLOYER NAME AND ADDRESS _____

OCCUPATION _____ LANGUAGE _____

OTHER PARENT/GUARDIAN

NAME _____ HOME PHONE _____
(LAST) (FIRST) (MIDDLE)

ADDRESS _____ CELL PHONE _____

CITY _____ ST _____ ZIP _____ WORK PHONE _____

SOCIAL SECURITY # _____ DATE OF BIRTH _____ SEX _____

E-MAIL ADDRESS _____ RELATIONSHIP TO PT _____

EMPLOYER NAME AND ADDRESS _____

PATIENT NAME

NAME _____ DATE OF BIRTH _____ SEX _____

NAME _____ DATE OF BIRTH _____ SEX _____

NAME _____ DATE OF BIRTH _____ SEX _____

NAME _____ DATE OF BIRTH _____ SEX _____

INSURANCE

PRIMARY INS. CO _____ ID# _____ GR _____

ADDRESS _____

NAME OF POLICY HOLDER _____ LAB REQUIRED BY INS _____

CONCERNING INSURANCE, PAYMENT AND NO SHOW POLICY

I agree to provide a current insurance card at each visit. I am aware that an insurance card with another provider name or no selection will not be accepted. If I cannot provide an insurance card or enrollment form, payment is expected in full at the time of service. If my insurance company has not made payment in 60 days, I will be responsible for paying the bill.

There is a charge for no show appointments not cancelled 24 hour before appointment.

Any necessary forms will be filled out at the time of the office visit at no charge.
There will be a charge for forms filled out at a non-appointment time.

If your account becomes past due, we will take necessary steps to collect this debt.
If we have to refer your account to a collect agency, you agree to pay all of the collection costs and any attorney fees.

X _____
Signature of parent, insured or beneficiary

Date

ASSIGNMENT OF BENEFITS

I hereby authorize payment of all medical insurance benefits which are payable to me under the terms of my insurance policy to be paid directly to the physician for services rendered. I further authorize the release of any information needed for processing my insurance claims. A copy of this authorization may be used in place of the original. I understand and agree that I am financially responsible for charges not paid by my insurance company.

X _____
Signature of parent, insured or beneficiary

Date

RISK MANAGEMENT

I understand that in the course of treating of my child, health care providers may be exposed to blood and other bodily fluids from my child in a way that can transmit the AIDS or Hepatitis B or C virus. If an employee of Manassas Pediatrics has had such exposure by accidental needle stick or other incident in the treatment of my child, placing the employee at risk, I agree to allow testing of my child's blood for those viruses mentioned above. The test results and other information will be provided only to me and the person exposed.

X _____
Signature of parent, insured or beneficiary

Date