Acct No: ______________________

# Pediatric Associates
OF DALLAS

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## Patient Registration Form

Date: ________________________ Doctor: ______________________
How were you referred to our office? ______________________________________________

Who should be listed as the statement recipient for the account? ______________________________
Relationship to the patient: __ Father __Mother __Other, please specify______________________
If other than parent: Date of Birth _____________ Drivers License #________________ SS#__________________
Marital Status: __Divorced __Married __Single

Street Address: ______________________________________________________ Apt. #: __________
City: __________________________ State: ____________ Zip: ________
What phone number should be listed as primary on the account? ______________________________

Children's Full Legal Name/s: Last, First, MI ____________________________ Date of Birth: ____________
____________________________ ____________
____________________________ ____________
____________________________ ____________
____________________________ ____________

Father's Legal Name: ______________________________ SS# ______________
Date of Birth: ______________________________ DL# ______________

Father's Employer: ________________________ Cell Phone # _______________Work Phone # _______________
Email: __________________________________________________

Mother's Legal Name: ______________________________ SS# ______________
Date of Birth: ______________________________ DL# ______________

Mother's Employer:________________________ Cell Phone # _______________Work Phone # _______________
Email: __________________________________________________

Preferred Pharmacy Name:______________________________ Phone # ______________
Address: __________________________________________________

Primary Insurance Company Name: ______________________________ Phone # ______________
Plan Type: ____________
(HMO, POS, PPO)

Policy Holder Name: __________________________________________
Date of Birth:______________________
Group (Employer Name or Self-Insured): ___________________________________
Insurance ID#: _____________________________ Group # ______________
Claims Address:__________________________________________________

- Upon the addition of dependents to this account or should you have multiple children with separate insurance carriers, you will be required to complete an additional form.

(Please see other side)

**Patient Name:** ______________________________________________________ **Date of Birth:** ___________________

## Financial Agreement

Pediatric Associates of Dallas ("PAD") files primary insurance only for services provided to patients with managed care organizations in which we participate. Co-payments, co-insurance, non-covered services and deductibles are the responsibility of the patient and payable at the time of service. Managed care patients are billed for any remaining patient responsibility after claims have been processed by the insurance company. Proof of insurance is not a guarantee of payment. Patients without insurance or covered under an insurance plan in which we are not contracted, are financially responsible for all charges incurred at the time of service. In the event that payment for a service performed is erroneously denied by the insurance carrier, it is the patient's responsibility to pursue action with the insurance carrier, as the policy is a legal contract between the patient and the insurance carrier. It is also the responsibility of the patient to be aware of plan benefits and your right to appeal claims. Insurance contracts are subject to change. Provider directories produced by Managed Care plans may not provide the most current information regarding plan participation and therefore are not a guarantee of our participation. Patients must verify plan participation with our office.

The maximum fee allowed by law will be charged for returned checks. A fee will be accessed for all after hour phone calls requiring medical advice, placed after regular office hours. Accounts are considered past due 60 days from the date a service is billed.

I request release of payment information to Pediatric Associates of Dallas, Inc. by third party payers, when required by coordination of benefits. Furthermore, I irrevocably assign any benefits available to me to PAD and I authorize payment of those benefits directly to that provider.

***ACCEPTANCE OF FINANCIAL TERMS***

**By signing this agreement, I accept the financial terms noted above and certify that the information contained on this form is true and correct. Furthermore, I understand it is my responsibility to present PAD with valid insurance information at each visit and inform PAD should any information on this form change at any time in the future.**

**Signature of Parent/Legal Guardian:** ________________________________________ **Date:** _______________

## Authorization To Release Protected Health Information

I, ________________________, hereby authorize Pediatric Associates of Dallas ("PAD") to disclose and release the relevant portions of my/my child's medical record(s) from each occasion of treatment to any third party payer (or their representatives), or any other individual as may be necessary to obtain payment for the Physician's services to me/my child, including for the purposes of coordination of benefits and prior authorization. I also authorize the Physician to disclose the medical information to other physicians or healthcare providers who are treating me/my child. Finally, I authorize the Physician to release such information as is necessary for the Physician to perform certain healthcare operations, such as to a utilization review committee or my/my child's insurance case manager and as required by federal, state or local law.

I understand that the information I am authorizing to be disclosed may contain references to psychiatric conditions, drug and alcohol abuse information, genetic testing information, and the results of specific laboratory tests, including HIV or AIDS diagnosis.

***A summary of your rights concerning you/your child's medical records is described in the Notice of Privacy Practices, which is being provided to you.***

As the party responsible for medical decision making for the child/children represented in this medical record, I hereby give my consent to the physicians and other healthcare employees of PAD to render both emergency and non-emergency healthcare services both in and out of my physical presence, and to perform all necessary diagnostic test. I also assume financial responsibility for any and all healthcare services provided to said patient/s.
A separate authorization form must be completed prior to releasing patient records to the patient/guardian, other individuals or agencies. These requests are processed in order of receipt. We do not process routine request for copies of medical records or the completion of health forms on a walk-in basis. Please be aware, there is a fee associated with the duplication of medical records for patients transferring out of the practice. It is illegal to deny patient records or refuse the transfer of records due to an unpaid or past due account balance, however records may be withheld for non-payment of the medical record fee.

***ACKNOWLEDGEMENT OF RECEIPT AND AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION***

**By my signature below, I acknowledge that I have received the PAD *Notice of Privacy Practices* on or prior to any service being provided to me by PAD following April 14, 2003.**

**In addition, I agree to the above terms of release of health information. I agree that I am voluntarily signing this form and that the authorization is valid only for the purposes described in the first paragraph. This authorization is in effect until revoked by the patient/legal guardian.**

**Signature of Parent/Legal Guardian:**____________________________________ **Date:**________________

**Relationship to Patient:**____________________________________________