Pediatric Associates
OF DALLAS

Patient Registration

Patient 1 _______________________________Sex___Date of Birth ____________
Patient 2 _______________________________Sex___Date of Birth ____________
Patient 3 _______________________________Sex___Date of Birth ____________

*Please check **all** that apply:*

Child(ren) live with ___Mother ___Father ___Step-Mother ___Step-Father ___Other______

Custodial Parent (where the child lives)

Last Name: ____ First Name:_________________________________
Spouse (step-parent name): ____
Street Address: ____
City: ____ State: __________ Zip: _______________________
Primary Phone: __________________________________ Alternate Phone: ___________________________
Employer: ____ Phone: _______________________ ext.: ________
SS#: _______________________ Email Address: ____

Other Parent

Last Name: ____ First Name:_________________________________
Spouse (step-parent name): ____
Street Address (if different):____
City: ____ State: __________ Zip: _______________________
Primary Phone: __________________________________ Alternate Phone: ___________________________
Employer: ____ Phone: _______________________ ext.: ________
SS#: _______________________ Email Address: ____

Emergency contact: ________________________________ Phone: _____________________________

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 that is "Out of Network", are financially responsible for all charges at the time of service or thereafter.** 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 their insurance carrier, as the policy is a legal contract between the two. 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 coverage. 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 after 60 days from the date a service is billed and are sent to collections after 90 days from the date of service.

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

ACCEPTANCE OF FINANCIAL TERMS

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

Signature of Parent/Legal Guardian:____ Date: _____________

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