**NEW PATIENT REGISTRATION FORM:**

Date: \_\_\_\_\_\_\_\_\_\_ Physician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason for Visit:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT INFORMATION**:

Patient’s Legal Name: Last\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_First\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Middle\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Name (if differs from above) : Last\_\_\_\_\_\_\_\_\_\_\_\_\_\_First\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Middle\_\_\_\_\_\_\_\_\_ Pronouns: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_ /\_\_\_ /\_\_\_\_\_ Sex: \_\_\_\_\_\_\_\_\_\_ Gender: \_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_St\_\_\_\_Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_St\_\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PARENT/GUARDIAN INFORMATION:**

Guardian #1 Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Guardian #2 Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address (if different)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PRIMARY INSURANCE:**

Insurance Co. Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Holder Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Specialty Visit Co-Pay: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If GUARANTOR address differs from the above provided address, please list here: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SECONDARY INSURANCE:**

Insurance Co. Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Holder Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Specialty Visit Co-Pay: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**POLICY ACKNOWLEDGEMENT AND AGREEMENT:**

I certify that the above information is correct, and hereby authorize payment directly to Pediatric Endocrine Associates P.C.. Although every attempt will be made to bill insurance directly, I understand that I am financially responsible to Pediatric Endocrine Associates P.C. for any co-payments, co-insurance or charges not covered by insurance or for charges incurred by failure to obtain insurance authorization. I acknowledge that I have read and agree to adhere to all office policies including release of information, consent for care, insurance information, missed appointments and payments. **Please be aware that we will vault your credit card and bill the card directly after your appointment for the remaining balance not covered by insurance. See “Vault Policy” for further information.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Insured Person or Authorized Rep. Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name of Insured Person or Authorized Rep.

**AUTHORIZATION TO RELEASE INFORMATION AND PRIVACY PRACTICES**

I authorize the release of information from the above named patient’s medical record that may be necessary to make reimbursement for any of all of the services rendered. I further understand that Pediatric Endocrine Associates, P.C. cannot be held responsible for the subsequent passage of information that might occur by the third parties themselves. I acknowledge that I have reviewed the HIPAA Notice of Privacy Practice document.

**MISSED APPOINTMENTS**

I understand that I am responsible for being on time for my appointments. **Failure to cancel an appointment 48 hours before the date will result in being billed a $50.00 “missed appointment fee” and $100.00 for a missed stimulation test**. If I am more than 10 minutes late for an appointment, it will be regarded as a missed appointment.

**CONSENT FOR CARE**

On behalf of the above named patient, I do hereby apply for and voluntarily consent to outpatient care for my child ordered by Sunil Nayak, MD; Alicia Marks, DO; Rebecca Somershoe, CNP; Lisa Farr, RD, CDE; Judy Bonnett, RN.

**INSURANCE INFORMATION**

**Please note:** If your insurance plan requires a referral, *you are responsible for ensuring the referral is available at the time of the appointment*. Please present your insurance card at the time of the patient’s appointment and be prepared to pay any necessary co-payment. Co-payments are due at the time of service (cash, check, Visa, MasterCard, Discover accepted).

**PAYMENT INFORMATION**

PEA has partnered with Retriever Medical to securely store patients’ debit/credit card information. Retriever Medical provides encrypted and secure storage of patient credit/debit card information in strict accordance with the Payment Card Industry Data Security Standards (PCI DSS). These are global standards for transmission and storage of financial data. For more information, please go to <https://www.pcisecuritystandards.org>. If you have an outstanding balance, we will make arrangements with you at your visit to collect the balance, either in full or via a payment plan with automatic monthly billing to your credit card. If you have a co-payment due at the time of service, this amount will also be collected. In addition, if we have your deductible information, we may request to charge your credit card for the balance due from the visit. We will reconcile this amount once your insurance carrier has processed our claim for services provided.

**AUTHORIZATION TO LEAVE LAB RESULTS**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, parent/representative of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, D.O.B. \_\_/\_\_/\_\_\_\_, give Pediatric Endocrine Associates the authorization to leave any lab results on the following voicemails:

Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**E-PRESCRIBING SYSTEM**

Please provide your preferred pharmacy below:

**Local Pharmacy Mail Order Pharmacy (If Applicable)**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**RELEASE OF HEALTH INFORMATION PATIENT OVER 18 YEARS OLD**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, D.O.B. \_\_\_/\_\_\_/\_\_\_\_\_, am 18 years or older. I give permission to Pediatric Endocrine Associates to release my health information to the following people at the following numbers:

Name/Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name/Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name/Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_