Southern Indiana pediatrics

REGISTRATION FORM

PLEASE FILL IN ALL APPROPRIATE BLANKS AND INSURANCE INFORMATION ON BACK

Father's Information: Relationship to Patient:					
Name			SS#		
Street			Employer		
City	State	Zip	Street		
	Birthdate		City	State	Zip
Phone (Home) (cell) (work) Email			Occupation		

Mother's Information: Relationship to Patient:					
Name			SS#		
Street			Employer		
City	State	Zip	Street		
	Birthdate		City	State	Zip
Phone (Home) (cell) (work) Email			Occupation		

NEAREST RELATIVE NOT LIVING WITH YOU:

Name	Relationship to child	Phone (Home)	(work) (cell)
Street	City	State	Zip

YOUR CHILDREN:

	LAST	FIRST	MIDDLE	BIRTHDATE	SEX	RACE	ETHNICITY
1.							
2.							
3.							
4.							
5.							

Name of Pharmacy used. Location _____

NO SHOW APPOINTMENT: I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO NOTIFY, IN ADVANCE, SOUTHERN INDIANA PEDIATRICS IN THE EVENT THAT I MUST CANCEL AN APPOINTMENT. I AM FULLY RESPONSIBLE FOR THE CHARGE FOR $20.00 WHICH WILL BE APPLIED TO MY ACCOUNT FOR APPOINTMENTS THAT ARE MISSED WITHOUT NOTIFYING THE OFFICE. A PATTERN OF MISSED APPOINTMENTS WILL RESULT IN YOUR FAMILY BEING DISMISSED FROM OUR PRACTICE.

HIPAA ACKNOWLEDGMENT:

I hereby acknowledge that I have received and had an opportunity to ask questions concerning Southern Indiana Pediatrics Notice of Privacy Practices.

_____ _____

PARENT OR PARENT'S REPRESENTATIVE DATE

_____ _____

REPRESENTATIVE'S RELATIONSHIP TO PATIENT DATE

SIGNATURE: _____ DATE: _____

INSURANCE INFORMATION

Please read the following information carefully. It is very important that we let you know these details to help you use your insurance.

Our office is happy to help you complete and file claims with your insurance carrier. Since the terms of coverage are an agreement between you and your insurance company, questions and problems concerning your policy will need to be directed to your insurance company. **We are happy to file your claims for you at no charge.**

Each insurance company has a different policy covering your medical costs. Even within the same company the coverage and benefits vary. **You are responsible for knowing the details of your coverage**. That includes what are covered and not covered services. In addition, **you are responsible for any co-payment or deductible not covered by your insurance**. In cases where there is no insurance coverage, the balance is due at the time of service. Co-payments are due at the time of service. If you are not prepared to pay the co-pay, you will be asked to reschedule.

Some insurance companies will only pay for services that are deemed by them to be "reasonable and necessary." If your insurance company determines that a particular service, although it would be otherwise covered, is "not reasonable and necessary" under their program standards, your company could deny payment to us for that service.

PRIMARY INSURANCE		SECONDARY INSURANCE	
INSURANCE COMPANY NAME ☐ PRIVATE ☐ GROUP		INSURANCE COMPANY NAME ☐ PRIVATE ☐ GROUP	
ADDRESS OF COMPANY		ADDRESS OF COMPANY	
NAME AS IT APPEARS ON INSURANCE CARD		NAME AS IT APPEARS ON INSURANCE CARD	
POLICY HOLDER (Company name if group)		POLICY HOLDER (Company name if group)	
ID#	GROUP #	ID#	GROUP #

In order to submit a claim for payment to us for services covered under your policy, we must have your authorization to release medical information to your insurance carrier.

ALL OTHER INSURANCE:
I hereby authorize my Doctor to submit a claim to my insurance carrier or its intermediaries for all covered services rendered by the physician and do irrevocably assign and transfer benefits covered by my insurance carrier or its intermediaries to issue payment check(s) directly to the physician(s) rendering covered services.

I authorize my Doctor to furnish complete information to my insurance carrier or to its intermediaries regarding services rendered.

REFERRALS PROCESS

We will do our best work within your insurance's guidelines to help you obtain maximum benefits from your insurance carrier. We strongly suggest that you become familiar with your insurance company's requirements.

If one of our physicians are listed as the primary care physician make sure you contact us before seeing a physician specialist.

WE CANNOT BE RESPONSIBLE FOR CLAIMS THAT ARE REJECTED BECAUSE A REFERRAL WAS NOT OBTAINED BY YOU IF YOU DO NOT FOLLOW THE GUIDELINES OF YOUR INSURANCE COMPANY.

ASSIGNMENT AND RELEASE

I hereby authorize payment directly to Southern Indiana Pediatrics, P.S.C. all insurance benefits otherwise payable to me for service rendered. I understand that I am financially responsible for all charges whether or not paid by insurance, for all services rendered on my behalf or my dependents. I authorize doctors and/or provider or supplier of services in this office to release any information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I request and give consent to any physician to provide and perform such medical/surgical care, test, procedures, drugs and other services and supplies as are considered necessary or beneficial by my physician.

SIGNATURE OF PARENT / GUARDIAN _____ DATE _____