Children's Choice Pediatrics

Patient Registration Form

Disclosures & Consents

Patient name: _____Date of Birth:_____
(Last Name) (First Name)

ASSIGNMENT OF INSURANCE BENEFITS:

_____I hereby authorize direct payment of my insurance benefits to Children's Choice Pediatrics or the physician individually for services rendered to my dependents, or me by the physician or those under her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that verification of my benefits is not a guarantee of payment and that I will be responsible for any co-pay or balance due that Children's Choice Pediatrics is unable to collect from my insurance carrier for whatever reason.

LAB/X-RAY/DIAGNOSTIC SERVICES:

_____I understand that I may receive a separate bill if my medical care includes labs, x-rays, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balances due for these services if they are not reimbursed by my insurance for whatever reason

MEDICARE/MEDICAID/CHAMPUS INSURANCE BENEFITS:

_____I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my or my dependent's records that these programs may request. I hereby direct that payment of my or my dependent's authorized benefits be made directly to Children's Choice Pediatrics or the physician on my behalf.

AUTHORIZED TO RELEASE NON PUBLIC PERSONAL INFORMATION:

_____I certify that I have read and been offered a copy of the Children's Choice Pediatrics "HIPAA Notice of Privacy Practices". I hereby authorize Children's Choice Pediatrics or the physician individually to release any of my or my dependent's medical or incidental nonpublic personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

AUTHORIZATION TO MAIL, CALL, OR E-MAIL:

_____I certify that I understand the privacy risks of the mail, phone calls, and email. I hereby authorize Children's Choice Pediatrics representative or physician to mail, call, or email me with communications regarding my healthcare, including to but not limited to such things as appointment reminders, referral arrangements, and diagnostic test results to the phone number and/or email address listed below.

Email_____Phone_____

_____I understand that I have the right to rescind this authorization at any time by notifying Children's Choice Pediatrics to that effect in writing.

CONSENT TO TREATMENT:

_____I hereby consent to the evaluation, testing, treatment as directed by my Children's Choice Pediatrician physician or those under her supervision.

Patient Signature:_____Date:_____

Guarantor Signature:_____Date:_____

Guarantor Name(Please Print)_____