Acct # _____

FAMILY REGISTRATION

Patient Information (Please list **all children in the family** and use legal name)

Patient Name: _____ **DOB:** _____ **M / F**
Patient Name: _____ **DOB:** _____ **M / F**
Patient Name: _____ **DOB:** _____ **M / F**
Patient Name: _____ **DOB:** _____ **M / F**

If parents are divorced or separated please fill out this section:

Who has physical custody? : _____
Have the legal rights been terminated for either parent? Yes / No
If yes please provide a copy of any legal paperwork that supports this restriction.
Parent/Guardian Relationship to Child: _____
Parent/Guardian: _____ **M / F** **DOB:**_____ **SS#:** _____
Primary Phone #: _____ **Secondary Phone #:** _____
Email: _____
Address: _____ **Zip Code:** _____
Place of Employment: _____ **Occupation:** _____

Parent/Guardian: _____ **M / F** **DOB:**_____ **SS#:** _____
Primary Phone #: _____ **Secondary Phone #:** _____
Email: _____
Address: _____ **Zip Code:** _____
Place of Employment: _____ **Occupation:** _____

Indicate your preference for receiving confirmations for appointments:

Circle One: Phone Message / Text Message Number to Call: _____

***How did you hear about our practice?** Friend / Neighbor / Doctor / Insurance / Website

***Whom may we thank for referring you?** _____

Financial/Privacy Policies (HIPAA)

(Initial) _____ I authorize PAMPA to treat the above-named child.

(Initial) _____ I authorize the release of medical and billing information to the insurance company so that payment for charges can be processed.

(Initial) _____ I understand that in order for PAMPA to file my insurance, I must present a valid card at the time of each visit. If no proof of insurance is provided I must pay for the services rendered at the time of service.

(Initial) _____ I authorize my children to receive health services with the understanding that if our insurance or managed care company determines that any services provided are non-covered services, I will be billed and held responsible for services rendered. Co-pays, deductibles and co-insurance amounts are due at time of service. A billing fee of $15 a month will be applied to any balance not paid at time of service.

(Initial) _____ I acknowledge the Administrative Fee (ASF) is a yearly fee intended to cover the cost of certain administrative services we may provide which are not covered by your insurance.

(Initial) _____ I acknowledge the cancellation policy which states that PAMPA requires a 24-hour cancellation notice for all well child check up visits and consultations. A $25.00 fee will be assessed per child for any missed or cancelled appointments without appropriate notice. Your cancellation must be made during regular office hours. As always, emergencies and unforeseen circumstances are taken into consideration.

Insured or authorized person's signature: _____ Date _____

Print Name: _____

Form Completed By: _____ **Relationship to child/children** _____

Form Updated: **Date/Initial** _____ **Date/Initial** _____ **Date/Initial** _____