ST. JOSEPH PEDIATRICS
PATIENT REGISTRATION FORM

PATIENT INFORMATION

Today's Date: _____ Home Phone: _____ Cell Phone: _____

Child's Name: _____ Social Security #: _____
Last Name *First Name* *Middle Initial*

Sex: Male / Female Age: _____ Birth date: _____

Street Address: _____ P.O. Box#: _____

City: _____ State: _____ Zip Code: _____

Temporary Address: _____ Pharmacy: _____

INSURANCE INFORMATION--PLEASE PRESENT ALL INSURANCE CARDS TO RECEPTIONIST

Person Responsible for Payment: _____ SS # _____ Date of Birth: _____

Relationship to Patient: _____ Address: _____

Employed by: _____ Work Phone: _____

Insurance Coverage Yes No What type of insurance do you have? _____

In case of emergency, please notify: _____ Relationship _____ Phone#: _____

I, the undersigned have insurance & assign direct payment to ST. JOSEPH HEALTH SYSTEM, realizing I am responsible to pay all non-covered services & authorize the release of pertinent medical information to insurance carriers; **OR**, I have no insurance coverage & I accept all responsibility for charges & will pay at the time service is provided. I authorize the administration of such medical/surgical procedures which are advised by the provider. I (or the person I am authorizing treatment for) understand & agree that tests for HIV or other serious communicable diseases may be performed upon me or samples of my body fluids, without further consent, in the event that my health professional or other person employed by ST. JOSEPH HEALTH SYSTEM sustains a percutaneous, mucous membrane or open wound exposure to my blood or other body fluids. I further understand & agree that such health professional or employee of ST. JOSEPH HEALTH SYSTEM and I will be informed of any positive results of such testing.

_____
Signature of Caregiver *Date*

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO INTERESTED PARTY

I hereby authorize St. Joseph Pediatrics staff to release medical information about my child to the following person or persons:

Name: _____ Relationship: _____ Phone#: _____

Name: _____ Relationship: _____ Phone#: _____

Caregiver Signature: _____ *Date:* _____

TO BE COMPLETED BY CAREGIVER

1. Do you (or patient) have any difficulties with your reading or sight?? Yes / No If yes, please explain:
   _____
2. Do you (or patient) have any hearing difficulties? Yes / No
3. What language(s) do you (or patient) speak? _____

TO BE COMPLETED BY MEDICAL PRACTICE STAFF

Any barriers noted? Yes / No If yes, what alternative methods of instruction will be used?

_____

Reviewed by: _____ Date: _____ Updated: _____ Updated: _____

St Joseph Pediatrics
Tawas City, Michigan

Request for Confidential Telephone Communications

Patient Name: _____ DOB: _____

I hereby request to receive confidential telephone communications from the practice in the following manner:

Phone number where I wish to be contacted: _____

- You may leave protected health information on my voicemail or answering machine (lab or test results, information about scheduling or prep for a test or procedure or information regarding follow up with a specialist).
  Yes _____ No _____

- You may communicate protected health information with a family member (other than me or my spouse):
  Yes _____ No _____

If yes, please list the family member(s) name(s):

_____ _____ _____

_____ _____
Signature of Parent/Legal guardian Date

_____ _____
Verbal Discussion: Staff signature Date

* Note: St Joseph Pediatrics reserves the right to communicate sensitive information only to the patient/parent/legal guardian.

Acknowledgement of Receipt of Privacy Notice
(HIPAA-δ 164.520 ©, Effective as of: 04/14/2003, Revised 2/2012)

I, the undersigned, have received the Notice of Privacy Practices from St. Joseph Health System.

_____ _____
Signature of Patient Representative **Date**

_____ _____
Witness **Date**

Peds-10

St Joseph Pediatrics
Financial Policy

Patient Name: _____

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment.

All patients must complete our information and insurance form prior to seeing the doctor.

Full payment is due at the time of service.
We accept cash, check and credit card.

Regarding Insurance

We may accept assignment of insurance benefits. The balance is your responsibility whether your insurance pays or not. We cannot bill your insurance company unless you give us your insurance information and we make a copy of your insurance card for our records. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary by your medical insurance.

Regarding Insurance Plans where we participate as a provider, all co-pays and deductibles are due at the time of treatment. In the event that your insurance coverage changes to a plan in which we are not participating as a provider, please refer to the above paragraph.

Usual and Customary

Our practice is committed to providing the best treatment for our patients, and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.
I have read, understand and agree to the Financial Policy.

_____ _____
Signature of Responsible Party Date

_____ _____
Signature of Co-Responsible Party Date

St. Joseph Pediatrics Patient Payment Policy

Thank you for choosing our practice! We are committed to the success of your medical treatment and care. Please understand that payment of your bill is part of this treatment and care.

For your convenience, we have answered a variety of commonly-asked financial policy questions below. If you need further information about any of these policies, please ask to speak with a Billing Specialist or the Practice Manager.

How may I pay?

We accept payment by cash, check, Visa, Mastercard and Discover.

What is my financial responsibility for services?

Your financial responsibility depends on a variety of factors explained below.

Office Visits and Offices Services

If you have…….	You are Responsible For…..	Our staff will…….
Commercial Insurance Also known as indemnity, "regular" insurance, or "80%/20% coverage."	Payment of the patient responsibility for all office visits, injections and other charges at the time of office visit.	Call your insurance company ahead of time to determine deductibles and coinsurance. File an insurance claim as a courtesy to you.
HMO & PPO plans with which we have a contract	If the services you receive are covered by the plan: All applicable co-pays and deductibles are requested at the time of the office visit. If the services you receive are not covered by the plan: Payment in full is requested at the time of the visit.	Call your insurance company ahead of time to determine co-pays, deductibles, and non-covered services for you. File an insurance claim on your behalf.
HMO with which we are not contracted.	Payment in full for office visits, injections and other charges at the time of office visit.	Provide the necessary information for you to complete and file your claim directly with the insurance company.

If you Have……..	You are Responsible For…….	Our staff will…….
Point of Service Plan or Out of Network PPO	Payment of the patient responsibility-deductible, co-pay, non-covered services-at the time of the visit.	Call your insurance company ahead of time to determine out of network benefits, and non-covered services. File an insurance claim on your behalf.
No insurance	Payment in full at the time of the visit.	Work with you to settle your account. Please ask to speak with our staff if you need assistance.