PATIENT REGISTRATION

PATIENT INFORMATION

LAST NAME_____ **FIRST NAME** _____**MI**____ **Sex: ( )M**
( ) F

Date of Birth:_____ /_____/_____ **SSN#**_____-_____-_____

PARENT/GUARDIAN:

Last Name _____First Name _____MI_____

DOB: _____/_____/_____ SSN#_____-_____-_____ TDL_____ Marital Status: S/M/W/D/SEP

Primary Contact Number (____) _____-_____ ___ home ___ mobile __ other: _____

Secondary Contact Number (____) _____-_____ ___ home ___ mobile __ other: _____

Address: _____ City/State/ Zip: _____

Email:_____

Relation to Patient: _____ If mother Maiden Name _____

EMPLOYER INFORMATION: Employer Name_____

Work # (__) _____-_____ Address _____ Occupation: _____

PARENT/GUARDIAN:

Last Name _____First Name _____MI_____ DOB:

____/_____/_____ SSN#_____-_____-_____ TDL_____ Marital Status: S/M/W/D/SEP

Primary Contact Number (____) _____-_____ ___ home ___ mobile __ other: _____

Secondary Contact Number (____) _____-_____ ___ home ___ mobile __ other: _____

Address: _____ City/State/ Zip: _____

Email:_____

Relation to Patient: _____ If mother Maiden Name _____

EMPLOYER INFORMATION: Employer Name_____

Work # (__) _____-_____ Address _____ Occupation: _____

INSURANCE INFORMATION: **PRIMARY** Insurance Company Name: _____

Subscriber ID #: _____ Group #: _____

Policy Card Holder: Last Name: _____ First Name: _____

Relation to Pt _____DOB: ____/____/_____SSN#_____-____-_____

SECONDARY Insurance Company Name: _____

Subscriber ID #: _____ Group #: _____

Policy Card Holder: Last Name: _____ First Name: _____

Relation to Pt _____DOB: ____/____/_____SSN#_____-____-_____

PERFERRED PHARMACY: Name: _____

Street Address: _____ Phone#: (__) ____-_____ Fax# (__) ____- _____ How were you referred to our office: Yellow Pages / Phone Book/ Friend/ Insurance/ Employer/ Other _____ Name of Sibling's seen here at Sniffles & Giggles_____

_____

_____ **Printed**

Name Parent/Legal Guardian/Responsible Party

_____

Signature of Parent/Legal Guardian/Responsible Party

_____

DATE

Patient Name: _____ **DOB:** _____/_____/_____

ASSIGNMENT OF BENEFITS

In the event that services rendered are not paid for by the responsible party, I hereby authorize payment of insurance benefits to **Sniffles & Giggles, LLC** and any assisting providers for services rendered. I understand that I am financially responsible for all charges, whether or not they are covered by insurance. I hereby authorize this healthcare provider to release all information necessary to secure payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

_____ _____

Parent or Legal Guardian Signature Date

CONSENT FOR TREATMENT

I, the undersigned, do hereby agree and give my consent for **Sniffles & Giggles, LLC** to furnish medical care and treatment to my child _____.

I give permission for the following people to bring my child to the office:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

_____ _____

Parent or Legal Guardian Signature Date

TELEPHONE/EMAIL CONTACT AUTHORIZATION

In compliance with Federal HIPAA Privacy Regulations, by providing your information and signature below you will authorize our office to leave a detailed message on your answering machine/voice mail/email that may include any information regarding your child's appointment, lab and x-ray results, and other private health information protected by privacy rules. Please list any additional contact information other than what is listed under parent/guardian.

Phone: _____ **Phone:** _____ **Email:**_____

_____ _____

Parent/ Legal Guardian Signature Date

NOTICE OF PRIVACY PRACTICES

I, the undersigned, do hereby confirm that I have been given access to and have reviewed a copy of **Sniffles & Giggles, LLC** HIPAA Notice of Privacy Practices.

_____ _____

Parent/ Legal Guardian Signature Date

FINANCIAL POLICY

We would like to thank you for choosing Sniffles & Giggles, LLC as your medical provider. To keep you informed of our current office and financial policies we ask that you read and sign our financial acknowledgement prior to any treatment.

Credit Card Policy: Master Card, Visa and Flexible Spending Account Cards are accepted for services rendered. Your credit card / bank account will be charged at the time services are rendered.

No Insurance: Payment will be due at the time of service. If you are unable to pay your balance in full, you will need to make prior arrangements with our office.

Insurance: Your insurance policy is a contract between you, your employer and the insurance company. Deductibles, co-payments, and non-covered charges are determined by your insurance plan. Please bring your insurance card with you at the time of your appointment. For insurance plans that we contract with, your carrier requires that all co-pays be paid prior to any services being rendered. The co-pay requirement placed on you by your insurance carrier and cannot be waived by our practice (any exceptions will be determined on a case by case basis). If you do not have your co-pay at the time of your visit, contact our office prior to your appointment. Questions regarding what is or is not covered by your plan should be directed to your insurance company. You are responsible for any co-insurance, deductibles or non-covered services as required by your insurance. You will receive a statement from our office indicating what your insurance has paid. Any remaining balance is due upon receipt of that statement. Payment for any services that we provide will ultimately be your responsibility if not paid promptly by another party.

Preventative Well exam: Includes a general exam, vital signs as well as a vision and hearing screening. Additionally, we may perform a hemoglobin check for anemia or an MCHAT screening, which will require additional payment. **Any other additional findings and/or complaints addressed during a preventative exam will be subject to a sick visit. Co-payments and/or deductible as required by insurance coding and billing guidelines will apply. For example there will be additional charges for cough, ear complaints, sore throat, asthma, ADHD-ADD, a new prescription, or a prescription refill, referral etc. Return Checks:** A $25.00 charge will be added to your account for any check returned by your bank for any reason.

Forms: There will be a charge of $25.00 for the completion of medical forms. Payment is due at the time that you pick-up the forms. Please allow 7-10 business days for the completion of these forms.

Medical Records: We will provide you a copy of your medical records upon request. You will need to sign a letter of release at the time of pick-up. Please allow 3-5 business days for us to copy your records.

After Hour Services : All after hours calls will be answered in a timely manner by the physician on call.

Medication Refills: Please allow 48 hours for medication refills to be processed.

Appointment No Show Policy: Failure to cancel your appointment within 24 hours notice will result in a $25.00 charge. This will be enforced on the 3RD no show, no call. This charge must be paid prior to your next appointment.

Late Appointment Policy: If you are 15 minutes late you will be asked to reschedule your appointment. If your child is sick, you may wait in the office and be worked in between patients. Please note there will be an extended wait time. Thank you for allowing us to be part of your children's lives.

_____ _____

Parent or Legal Guardian Signature Date