KIDS COUNT PEDIATRICS
PATIENT REGISTRATION FORM

PLEASE COMPLETE THIS FORM IN ITS ENTIRITY - PLEASE READ AND SIGN THE THREE STATEMENTS ON PAGE 2

Office Use Only
KCP RCD# _____

☐ Patient ☐ Guarantor ☐ Patient Same as Guarantor

Patient Name: _____
Prefix *First* *Middle* *Last* *Suffix*

Address: _____

City: _____ State _____ Zip Code: _____

Home Phone: _____ (Cell/Work/Other): _____

Birthdate: _____ Social Security #: _____

Marital Status: _____ Sex: Male / Female Occupation: _____

Employer: _____ Employment Status: _____

****** Insurance - Primary** [ ]Same as Patient [ ]Same as Guarantor [ ]Other

Insurance Name: _____

Insurance ID: _____ Other Insurance ID: _____

Policy Group: _____ Group Name: _____

****** Insurance - Secondary** [ ]Same as Patient [ ]Same as Guarantor [ ]Other

Insurance Name: _____

Insurance ID: _____ Other Insurance ID: _____

Policy Group: _____ Group Name: _____

Patient Race: _____ Patient Is Student: No / Full Time / Part Time

Guarantor Information (Person Responsible for Payment of Services not covered by Insurance)

Guarantor Name: _____
Prefix *First* *Middle* *Last* *Suffix*

Address: _____

City: _____ State _____ Zip Code: _____

Home Phone: _____ (Cell/Work/Other): _____

Birthdate: _____ Social Security #: _____

Marital Status: _____ Sex: Male / Female

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VERIFICATION OF INFORMATION

I affirm that all of the information provided on the previous page is true and accurate to the best of my knowledge. I also acknowledge and understand that I must bring a copy of my insurance card for each visit to confirm that my coverage is still in effect. I understand that failure to bring my card to each and every visit may require me to pay full charges at the time of my visit.

_____ _____

Patient or Guardian *Date*

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize release of all medical information necessary to process my insurance claims or that are pertinent to my medical care. I authorize payment of medical benefits to Kids Count Pediatrics. I also request payment of any government benefits to Kids Count Pediatrics. I understand that Kids Count Pediatrics is a Provider Based Facility which will include billing for Part A and Part B of my insurance if I have Medicare. I understand that if I fail to comply with the stipulations set forth in this paragraph or with my particular insurance policy, that I will be responsible for any and all non-reimbursed charges, including any fees incurred by KCP to collect my payments.

I further understand that I am responsible for any services provided to me that are not reimbursed by my insurance policy, including but not limited to co-pays, deductibles, and/or non-covered services. I understand that should my insurance company, or I fail to reimburse Kids Count Pediatrics for services received, I can be refused further services and dismissed from the practice.

_____ _____

Patient or Guardian *Date*

HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

I acknowledge that I have received and read the HIPAA material of Kids Count Pediatrics (by handout, office posting, or Internet posting).

☐ Yes, I accept this material

☐ No, I have refused to read and accept this material

_____ _____

Patient or Guardian *Date*

As required by the HIPPA you have a right to request that communications concerning your personal health information be made through confidential channels. In an effort to better serve our patients, we are asking that you sign below indicating your preference of how we should provide you with test results.

☐ Yes, you may leave any test/lab results or appointment information with a family member. Please list any names that we may leave information with about any of the above. _____

_____

☐ Yes, you may leave any test/lab results or appointment/referral information messages on my answering machine.

☐ I want any and all test/lab results or appointment/referral information given to me only.

_____ _____

Signature *Date*