Registration Form Beckley Pediatric Associates

Patient Name_____DOB_____SS_____

Mailing Address_____City_____

Zip_____Phone_____Alternate#_____

Circle One: Single Married Divorced Sex M F Race African American Hispanic Caucasian Other Ethnicity Hispanic Non Hispanic Pref Language English Other

Guardian/Mother's Name (This Means Whoever Has Custody)

Name_____DOB_____SS_____

Mailing Address_____City_____

Zip_____Phone_____Cell Phone_____

Circle One Single Married Divorced Sex M F Race African American Hispanic Caucasian Other Ethnicity Hispanic Non Hispanic Pref Language English Other

Guardian/Father's Name (This Means Whoever Has Custody)

Name_____DOB_____SS_____

Mailing Address_____City_____

Zip_____Phone_____Cell Phone_____

Circle One Single Married Divorced Sex M F Race African American Hispanic Caucausian Other Ethnicity Hispanic Non Hispanic Pref Language English Other

Email_____

Pharmacy (Be Specific)_____

IN CASE OF EMERGENCY

Name and number of nearest relative NOT living with you

Name_____Number_____
Name_____Number_____

OVER→

Insurance Information (Show all cards to Receptionist)

Authorization to Pay Benefits to the Physician

I hereby authorize the office of Beckley Pediatric Associates, to release any medical information required during the course of examination and treatment and permit payment directly to them any benefits due for their services rendered. I recognize and accept responsibility for services rendered or responsible party listed on page one of this form. This includes but is not limited to co-insurance, copayment, deductible and non covered services.

Signature_____**Date**_____

Insurance Authorization

I request that payment of authorized insurance benefits be made on my behalf to Beckley Pediatric Associates, for any services furnished to me by that Physician or that supplier. I authorize any holder of medical information about me to release to my Insurance and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature_____**Date**_____

Due to the excessive amount of **NO SHOW** appointments after **3** (three) **NO SHOWS** you could be discharged from the practice. **NO SHOWS** consist of having a scheduled appointment and not calling the office or answering service within 24 hours to cancel or reschedule, and or making a same day appointment and not showing up.

I have read and fully understand this policy.

Patient Name:_____

Responsible Party Name:_____
Date:_____

Beckley Pediatric Associates 30 Mallard Ct Beckley, WV 25801

HIPAA FORM (MUST BE SIGNED)

NOTICE of PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountablity Act of 1996 (**HIPAA**), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

Obtain payment from third party payors.

Conduct normal healthcare operations such as quality assessments and physicians certifications.

I have received, read and understand Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patients Name_____

Relationship to Patient_____

Signature_____ **Date**_____

OVER →

RELEASE OF INFORMATION TO FAMILY/FRIENDS

This form is for who will be permitted to bring your child to this office to be seen.

I,_____(Parent/Guardian) of (Patient)_____ realize that there may be times or situations when I may ask/need a friend or family member to bring my child(ren) to Beckley Pediatric Associates for necessary healthcare. I authorize Beckley Pediatric to release protected healthcare information regarding my child(ren) to the following people who may assist in the care of my child(ren).

Name	**Relationship**
_____	_____
_____	_____
_____	_____
_____	_____

Names of other children in household

_____

_____

_____

_____

Signature of Parent or Guardian_____ **Date**_____

F - 9 VO

Beckley Pediatric Patient Responsibility Form

Our goal is to provide and maintain a good physician patient relationship. Letting you know in advance of our office policy allows for a good flow of communication and enables us to achieve our goal. Please **READ** this carefully and if you have any questions, please do not hesitate to ask a member of our staff.

- **Responsible Party** - In the event the patient is a minor the responsible party will be the parent/guardian that presents the child for medical treatment.

- **Demographic Information**- In the event there are any changes in the demographic information (name, address, insurance guardianship) for patient or responsible party, it will need to be provided to the office as soon as the changes occur. Failure to advise of current medical insurance information changes may result in balance being deemed responsible party balance.
- **Patient Without Insurance** - Payment will be expected at the time of service. If you are unable to make payment in full you will need to make other payment arrangements with office staff. Monthly agreement extensions will be based on balance due and will not exceed 3 months. Default on monthly payment agreement may result in account being deferred to collections at time of default without further notice. If account goes to collections you will be expected to pay at time of service until account is paid in full.

- **Patient with Insurance** - It will be your responsibility to provide current correct medical coverage policy information at the time of service. Failure to do so will result in the balance being deemed a patient responsible balance. You are responsible for deductibles, copayments, non-covered services at time of service. Any other remaining balance after your insurance carrier has processed claims should be taken care of within one month of notice from insurance company. If you or your insurance carrier makes payment exceeding your balance, reimbursement will be remitted. If payment cannot be made at each visit, notify the front desk staff to make other arrangements before your appointment. If your carrier utilizes third party administrators for claims processing it will be your responsibility to follow up directly with your carrier.

- **Benefit Plan** - It is your responsiblility to understand your benefit plan. It is your responsibility to know if a written referral or authorization is required to see specialists, if pre authorization is required prior to a procedure and what services are covered.

- **Primary Care Physician** - If you have selected us as your primary care physician, make sure our name and number appears on your card. If your insurance company has not been informed that we are your primary care physician as of this date you may be financially responsible for the visit.

- **Contracted Insurance** - If our office is not contracted as a participating provider with your insurance plan we will do a one time claim submission to the carrier. If no payment is received within 30 days of claim submission the balance will be deemed a patient responsible balance. It is your responsibility to know who your carrier is contracted with.

- **NSF Checks** - In the event a check is returned for non-sufficient funds the responsible party will incur the assoociated cost/fee. You will then need to pay by credit card or cash only.

- **Collection Agency** - When an account is 90 days past due and the balance is not received, the account is turned over to the collection agency. In order for the collection agency to reach out to you for collections regarding the past due account, you are authorizing them to contact you at any telephone number you have provided the practice with including any wireless telephone numbers which could result in a charge to you. Contacting you could be related to any type of method such as pre-recorded voicemail messages, artificial voicemail messages, automatic telephone dialing systems, predictive telephone dialing systems, automated SMS text message reminders, and fax where applicable.

I have read and agree to the Financial Policy, Assignment, and Release of Information provided on this form.

Patient Name_____**Resp Party**_____**Date**_____