Swift Creek Pediatrics

REGISTRATION FORM

Patient Name: _____
(last) (First) (Middle)

Address:

Street: _____

City: _____, State: _____ Zip _____

Home Phone Number: (_____) _____-_____ Date of Birth: ____/____/____ Sex: Male / Female

Name(s) of the other in the family:_____

Who referred you to our practice?_____ Preferred Pharmacy: _____

Mother's Information:

Name: _____

Address: _____

City/State/Zip _____

Date of Birth _____

Home #_____Work #_____

Cell # _____

Employer_____

Father's Information:

Name: _____

Address _____

City/State/Zip _____

Date of Birth _____

Home #_____ Work #_____

Cell #_____

Employer_____

In case of emergency contact: Name:_____ Phone number_____

Billing Information:

Who is responsible for the charges not covered by insurance?_____
Relationship to patient: _____

Address where statements should be sent: _____

Primary Insurance Company_____Effective date_____

Who pays for the insurance policy for the child? mother/father/step-parent. Name of insured parent _____
Date of birth of insured parent_____

Secondary Insurance Company_____Effective date_____

Who pays for the insurance policy for the child? mother/father/step-parent. Name of insured parent _____
Date of birth of insured parent_____

I request the payment of insurance benefits be made on my behalf to Swift Creek Pediatrics (SCP) for any services furnished to my child by the physician(s) of SCP. I authorize any holder of medical information about my child to release to my insurance carrier any information needed to determine these benefits or benefits payable for related services. I understand that I am financially responsible for charges not covered by this authorization. I agree that in the event that my account must be turned over to an attorney and/or collection agency for collection, that I will be responsible for collection agency fees, attorney fees, court costs and interest.

Printed name: _____ Signature:_____ Date: _____

SWIFT CREEK PEDIATRICS
FINANCIAL POLICY

Thank you for choosing **SWIFT CREEK PEDIATRICS** as your healthcare provider. We are committed to the highest quality care. Please understand that payment of your bill is considered a part of the treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment.

Regarding Insurance

We may accept assignment of insurance benefits. However, we do require that all co-payments be made at time of service. The balance is your responsibility whether or not your insurance pays. We cannot bill your insurance company unless you give us your insurance information and an original insurance card to copy and keep on file. Your insurance policy is a contract between you and your insurance company. We are not party to that contract. Please be aware that some and perhaps all of the services provided may be non-covered services.

Initial_____

Returned Checks

There will be a $35.00 returned check fee on all returned checks. In the event that a check is returned for insufficient funds, we will call your bank to verify funds for any future checks that are presented for payment on your account.

Initial_____

Collection Fees

In the event that your account is turned over to a collection agency, you will be responsible for all collection costs including reasonable attorney's fees.

Initial_____

Missed Appointments

Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of $25.00 per missed appointment. Please help us to serve you better by keeping scheduled appointments.

Initial_____

Fees for Letters and Forms

Your healthcare provider will be more than happy to fill out any necessary form(s) you may need. Please be advised that due to the time required to dictate and complete letters and forms, there may be a fee for this service. These costs are considered non-covered by the insurance companies. A fee schedule is available upon request.

Initial_____

THANK YOU FOR UNDERSTANDING OUR FINANCIAL POLICY. PLEASE LET US KNOW IF YOU HAVE ANY QUESTIONS OR CONCERNS. I HAVE READ THE FINANCIAL POLICY. I UNDERSTAND AND AGREE TO THIS FINANCIAL POLICY:

X _____ **Date:** _____

Signature of Patient or Responsible Party

For your convenience, we accept cash, check, credit card (Visa, MasterCard), and debit card.

REORDER # 04-22666-30

Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of Your Protected Health Information
Your protected health information will be used by Swift Creek Pediatrics or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day –to-day health care operations of the practice.

Notice of privacy Practices
You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

Requesting a Restriction on the Use or Disclosure of Your Information
You may request a restriction on the use or disclosure of your protected health information. Swift Creek may or may not agree to restrict the use or disclosure of your protected health information. If Swift Creek Pediatrics agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent
You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change Privacy Practices
Swift Creek Pediatrics reserves the right to modify the privacy practices outlined in the notice.

Signature
I have reviewed this consent from and give my permission to Swift Creek Pediatrics to use and disclose my health information in accordance with it.

_____
Name of Patient

_____
Signature if Parent

_____
Date

_____
Signature of Patient Representative (if other than parent)

_____
Relationship of Patient Representative to Patient

Notice of Privacy Practices

Privacy Practices Acknowledgement
Swift Creek Pediatrics

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices, and I have been provided an opportunity to review it.

Patient Name_____Birthdate_____

Signature of Parent_____

Date_____