

HEBRON PEDIATRICS Patient Registration Form

Patient Name: _____ Sex: ____ Date of Birth: _____
Street Address: _____ Apt No: _____
City: _____ State: _____ Zip Code: _____
SSN: _____
Race (Please Circle): American Indian/Alaska Native Asian African-American White Other
Ethnicity (Please Circle): Hispanic Non-Hispanic

Mother/Guardian Name: _____
Date of Birth : _____ SSN: _____
Phone Number: _____ Email: _____
If address is same as above, check here
Street Address (If different): _____ Apt No: _____
City: _____ State: _____ Zip Code: _____

Father's Name: _____
Date of Birth: _____ SSN: _____
Phone Number: _____ Email: _____
If address is same as above, check here
Street Address (If different): _____ Apt No: _____
City: _____ State: _____ Zip Code: _____

Primary Insurance Name: _____
Name of Policy Holder: _____ SSN: _____
ID Number: _____ Group Number: _____

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Secondary Insurance (If applicable): _____
Name of Policy Holder: _____ SSN: _____
ID Number: _____ Group Number: _____

Pharmacy Name: _____
Pharmacy Address: _____
Pharmacy Phone Number: _____

Referred By (Please circle): Friend Doctor School Google Insurance Other _____

I warrant that I am the responsible party for making the medical decisions for the child represented in this medical record. I acknowledge that payment is due at the time of service, unless other arrangements have been made. I assume financial responsibility for any all healthcare services provided to this patient.

Signature of Parent/Legal Guardian/Guarantor

Date

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Office Policy

Statement of Financial Obligation

All payments are expected at the time of service.

This office is contracted with many different insurance plans. We will be happy to file your insurance claims, however you will be expected to pay your co-payment, deductible and/or co-insurance due at each visit. We accept cash or credit/debit card. Account balances past 60 days will incur a \$25 monthly charge until it is paid in full.

Primary Care Physician

If you are required by your insurance company to select a primary care physician, this must be done prior to your child's appointment. Your health insurance is a contract between you and your health insurance company. You are financially responsible for any non-covered services.

Private Pay Patients

If you do not have insurance, payment is due at the time services are rendered.

Statement of Benefit Obligation

All patients are expected to provide our office with current insurance information and to understand their benefits. For the convenience of our patients, our provider participates in a variety of managed care plans. This may include completing pre-certifications, eligibility verifications or similar paperwork on behalf of the patient. Ultimately, the patient is responsible for understanding their benefits and providing our office with current information so that we can handle this paperwork on their behalf in a timely manner.

Medical Records / Shot records/ School Forms

Our office has 30 business days to release your child's medical records. Please give our office 5 business days for your school forms, camp forms, and sports physical forms. Please note we do not provide printed copies of medical records except vaccine record. Digital copies picked up in the office is free of charge. Digital copies that need to be mailed out has a \$10 fee.

I have read, understood and will comply with the above policies. I understand that I am responsible for the charges occurred by my child/children regardless of insurance benefits. If by using the information I have provided today or on previous occasions, Hebron Pediatrics is unable to collect from my insurance company, I accept full responsibility for the payment of my bills.

Signature of Parent/Legal Guardian/Guarantor: _____

Date: _____

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Consent for Use and Disclosure of Health Information

I hereby permit Hebron Pediatrics to release and furnish all medical and financial data related to the patient that may be necessary now or in the future for the purpose of treatment, payment or healthcare operation to assist with, aid in, or facilitate the collection of data for purpose of utilization review, quality assurance or medical outcomes evaluation process. Such information may be released to insurance companies, HMO's and PPO's, managed care organizations, Medicare/Medicaid or other governmental or third party payers or any organization contracting with any of the above entities to perform such functions.

The Notice of Privacy Practices provided by Hebron Pediatrics provided complete description of how my Personal Health Information may be used and disclosed.

You have the right to request that this office restrict use and disclosure of your health information, however this office is not required to agree to requested restriction. Your treatment at this office is conditional upon signing this consent.

Signature of Parent/Legal Guardian/Guarantor: _____

Date: _____

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name: _____ Date of Birth: _____

Phone: _____

Previous Doctor/Facility Name: _____

Phone: _____ Fax _____

Address: _____ City/State/Zip: _____

I hereby authorize the release of the following records to:

Facility Name: Hebron Pediatrics Facility Phone: 972-695-9630 Fax: 972-694-0000

Facility Address: 2008 E Hebron Pkwy, Ste 120, Carrollton, TX 75007

The information requested is as follows:

- Immunization Records
- Other: _____

Parent/Guardian Signature: _____

Parent/Guardian Name: _____

Date: _____