Acton Road Pediatrics

PATIENT REGISTRATION

CELL NUMBER (TEXT REMINDERS): _____ CARRIER NETWORK: _____ EMAIL: _____

**IF PATIENT IS 14 OR OLDER, PATIENT'S CELL #: NUMBER? _____

PREFERRED NAME: _____ SEX: MALE ☐ FEMALE ☐ SOCIAL SECURITY #: _____

LAST NAME: _____ FIRST NAME: _____ MIDDLE: _____ DATE OF BIRTH: _____

STREET ADDRESS: _____ APT NUMBER: _____

CITY: _____ STATE: _____ ZIP CODE: _____ HOME PHONE: _____

ETHNITICITY: _____ RACE: _____ LANGUAGE: _____

PHARMACY: _____ **PHARMACY ADDRESS:** _____

MOTHER

LAST NAME: _____ FIRST NAME: _____ MIDDLE: _____

DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: _____

STREET ADDRESS: _____ APT NUMBER: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: _____ CELL PHONE: _____ WORK PHONE: _____

EMPLOYER: _____

FATHER

LAST NAME: _____ FIRST NAME: _____ MIDDLE: _____

DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: _____

STREET ADDRESS: _____ APT NUMBER: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: _____ CELL PHONE: _____ WORK PHONE: _____

EMPLOYER: _____

PRIMARY INSURANCE: _____ MEMBER ID: _____

SUBSCRIBER NAME: _____ GROUP #: _____ EFFECTIVE DATE: _____

SUBSCRIBER DATE OF BIRTH: _____ SUBSCRIBER SSN: _____

SECONDARY INSURANCE: _____ MEMBER ID: _____

SUBSCRIBER NAME: _____ GROUP #: _____ EFFECTIVE DATE: _____

SUBSCRIBER DATE OF BIRTH: _____ SUBSCRIBER SSN: _____

EMERGENCY CONTACT: _____ **HOME PHONE:** _____ **CELL PHONE:** _____

As pediatricians, we wish to provide your child with the best care possible. We may order certain routine laboratory tests and routine vaccinations that we feel are necessary for the maintenance of good health but that may not be covered by your insurance contract. You will be expected to pay for these services in full. We follow the American Academy of Pediatrics guidelines for child health maintenance and will only order a test if we truly believe that it is necessary for your child's health. I, the parent or guardian of the above child do, hereby authorize Acton Road Pediatrics, LLC, and all of its physicians to give to this child immunizations and treatments that such physicians deem necessary for his/her health.
I authorize the release of medical information on this child to other physicians and insurance providers as necessary for my child's care and in compliance with federal HIPAA policies. I acknowledge that I am totally responsible for all charges for services rendered to this child including non-covered services. If this account is referred to a collection agency or attorney for collection, I agree to pay all costs of collection. A returned check fee of $30 applies to all returned checks.

RESPONSIBLE PARTY SIGNATURE: _____ DATE: _____

NON-COVERED SERVICES WAIVER

PATIENT NAME: _____ **D.O.B:** _____

PATIENT NAME: _____ **D.O.B:** _____

PATIENT NAME: _____ **D.O.B:** _____

PATIENT NAME: _____ **D.O.B:** _____

NON-COVERED SERVICES STATEMENT: If you have any questions about whether or not a particular service is covered by your insurance or the amount of services being rendered please contact your insurance company. Depending on your health benefits contract there may be some services which may not be covered by your insurance. You will be expected to pay for these services in full following notification from your insurance carrier. As your child's provider, we will order only the test(s) and treatment(s) that we feel are necessary for your child's care.

MEDICAID: I understand that if I do not have a Medicaid referral from my assigned PMP on the date of service, I will be responsible for any charges incurred.

EXAMPLES OF POSSIBLE NON-COVERED SERVICES FOR PREVENTATIVE (ROUTINE) CARE WHICH MAY BE PROVIDED TODAY BY YOUR PHYSICIAN AND/OR ACTON ROAD PEDIATRICS STAFF ARE LISTED BELOW:

PHYSICIAN SERVICE: Preventative Care Physician Fee (Well Child Visit), Hearing and Vision Screenings
ADDITIONAL TREATMENTS: Issues addressed during a routine visit that would constitute an additional office visit charge.
LABS: CBC/Hematocrit/Blood Draw Fee, Urinalysis and Cholesterol
VACCINES: Vaccines/Antibiotic Injections/Vaccine Administration
OTHER: Allergy testing including lab charges, Developmental Testing and any other possible non-covered service

I have read this policy and agree to pay for all rendered services including those listed above and those that are not that are not covered by my insurance contract as indicated by my signature for each visit my child incurs.

1. CONSENT FOR TREATMENT: I the undersigned, consent to the care and treatment by the attending physician, her associates, or assistants.
2. I have reviewed the Policy and Procedures for Acton Road Pediatrics, LLC and agree to the NO SHOW/CANCELLATION POLICY which carries a fee of $25.00.
3. I understand that there will be a fee for form completion, blue forms, copies of medical records.

_____ _____

Patient/Parent/Guardian Signature Date