

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patient Name: _____
Sex: M F Birthdate: _____ Home Phone: _____
Last First Middle
Home Address: _____
Street (Apt#) City State Zip Code

FATHER'S INFORMATION

Name: _____
Social Security #: _____ Birthdate: _____ Marital Status: S M W D
Home Address: _____
Street (Apt#) City State Zip Code
Home Phone: _____ Cell Phone: _____
Work Phone: _____ Employer: _____

MOTHER'S INFORMATION

Name: _____
Social Security #: _____ Birthdate: _____ Marital Status: S M W D
Home Address: _____
Street (Apt#) City State Zip Code
Home Phone: _____ Cell Phone: _____
Work Phone: _____ Employer: _____

INSURANCE INFORMATION

Primary Insurance Company: _____ Effective Date: _____
Insured's Name: _____ Copay/Deductible Amount: _____
ID# _____ Group #: _____
Secondary Insurance Company: _____ Effective Date: _____
Insured's Name: _____ Copay/Deductible Amount: _____
ID# _____ Group #: _____

PLEASE READ AND SIGN BELOW

INSURANCE RELEASE: I hereby authorize the physician to release to any party responsible for payment any information acquired in the course of medical examination or treatment. A Photostat of the authorization shall be considered as effective and valid as the original. I request that payment of authorized benefits be made to me or my behalf to the party who accepts assignment, for any services furnished me by that supplier. I authorize any holder of medical information about me to release to the health care financing administration and its agents any information needed to determine these benefits or the benefits payable for related services.

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize the physician to receive direct payment for the amount due in my pending claim for physician's services rendered. I understand that I am financially responsible for charges not covered by this authorization. A Photostat of the authorization shall be considered as effective and valid as the original.

Signature of Patient, Parent or Legal Guardian: _____ Date: _____

(CONTINUED)

FAMILY MEDICAL HISTORY

PATIENT'S FULL LEGAL NAME: _____

BIRTHDATE: _____ NAME OF HOSPITAL: _____

SEX: _____ BIRTH WEIGHT: _____

PROBLEMS IN NURSERY: _____

OPERATION: _____

HOSPITALIZATIONS: _____

INJURIES: _____

CHRONIC ILLNESSES: _____

MEDICATIONS: _____

ALLERGIES: _____

SPECIALISTS: _____

NAME

AGE

HEALTH

MOTHER:

FATHER:

SIBLING:

SIBLING:

SIBLING:

DOES ANYONE IN THE FAMILY HAVE:

TUBERCULOSIS
SEIZURES
BLEEDING PROBLEMS
KIDNEY DISEASE
DIABETES
HEART DISEASE
HIGH CHOLESTEROL
ANEMIA

GENETIC SYNDROMES
MENTAL RETARDATION
PSYCHIATRIC ILLNESS
ASHTMA
ALLERGIES
HEADACHES
OTHER

Who referred you to our office? _____

Your previous pediatrician: _____

I hereby authorize Dr. Koenig and/or Associates (and their designated staff) to administer any medical treatment as deemed necessary.

Signature of Parent or Guardian

Date

Town & Country Pediatrics, PC
3009 N. Ballas, Suite 141A
Town & Country, MO 63131
Office 314-994-0209
Fax 314-994-9130

Financial Policy

This is an agreement between Town & Country Pediatrics, PC, as creditor, and the Patient/Doctor named on this form.

By executing this agreement, you are agreeing to pay for all services that are received.

Patient(s) Name: _____

Responsible Party: _____

Signature: _____ Date: _____

Payments: Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid by the due date.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, re-billing fee, and any payments or credits applied to your account during the month.

Payment options if you have no insurance: You may choose to pay by cash, check, or credit card on the day that treatment is rendered.

Payment options if you have insurance: You may choose to pay your co-pay, deductible or any out-of-pocket portions at the time services are rendered by cash, check, or credit card.

Insurance: Insurance is a contract between you and your insurance company. We are NOT a party to this contract, in most cases. We will bill your primary insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance.

Re-billing fee: A re-billing fee of \$5 will be imposed on each account that is over thirty (30) days past-due. We determine your account is past-due by taking the balance owed thirty (30) days ago, and then subtracting any payments or credits applied to the account during that time.

The financial policy continues on the back of this page.

Required payments: Any co-payments required by an insurance company must be paid at the time of service. Because this is an insurance requirement, we cannot bill you for these.

Returned checks: There is a fee (currently \$15) for any checks returned by the bank.

Missed appointment fee: Patients who do not show up on time for an appointment, or cancel with less than 24 hours notice will be charged a \$20 fee. This fee must be paid before a new appointment is scheduled. Patients with three missed appointments will be asked to transfer their records to another doctor.

Past due accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs which are incurred.

Waiver of confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Transferring of records: You will need to request in writing, and pay a reasonable copying fee (currently \$15 per chart) if you want to have copies of your records sent to another doctor or organization. You authorize us to include all relevant information, including your payment history. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history.

Co-signature: If this or another Financial Policy is signed by another person, that co-signature remains in effect until canceled in writing. If written cancellation is received, it becomes effective with any subsequent charges.

Effective date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

Town & Country Pediatrics, PC
3009 N. Ballas, Suite 141A
Town & Country, MO 63131
Office (314) 994-0209
Fax (314) 994-9130

OPEN AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name _____ Middle Initial _____ Last Name _____ DOB _____

I, [_____] hereby authorize **Town & Country Pediatrics, PC** to release any and All Protected Health Information (PHI) maintained in my child's Medical Record to the following Individuals, concerning my child's status as a patient, treatment or payment of services Provided by **Town & Country Pediatrics, PC**.

Name	Relationship to Patient
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

This authorization is given freely with the understanding that:

1. This authorization is valid for a period of 1 year, unless revoked by me.
2. I may revoke this authorization at any time, except where information has already been released, by completing Town & Country Pediatrics, PC's Revocation of Authorization Form.
3. Individuals listed on this form will be able to receive any and all information related to my status as a patient, treatment or payment of serviced provided to me by Town & Country Pediatrics, PC during the time period in which this authorization is valid.
4. Individuals not listed above will not be unable to receive any information regarding treatment or payment for services provided to me without my prior written authorization.
5. Town & Country Pediatrics, PC, and it's workforce members are hereby released from any legal responsibility or liability for disclosure of any of my Protected Health Information as indicated and authorized herein.

Parent's signature (or personal representative)

Date

Relationship to Patient

Witness

Town & Country Pediatrics, PC
3009 N. Ballas, Suite 141A
Town & Country, MO 63131
Office (314) 994-0209
Fax (314) 994-9130

CONSENT FORM

I understand as part of my healthcare, Town & Country Pediatrics, PC originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plan for future care or treatment. I understand this information serves as:

- A basis for planning my care and treatment;
- A means of communication among the many health professionals who contribute to my care;
- A source of information for applying my diagnosis and health information for billing purposes;
- A means by which a third-party payer can verify that services billed were actually provided;
- And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I have received the Town & Country Pediatrics, PC's *Notice of Privacy Practices*, which provides a more complete description of information uses and disclosures. I have the right to review this notice prior to signing this consent. I understand the organization reserves the right to change their notice and practices at any time and I may request a copy of any revised notice by contacting Town & Country Pediatrics, PC's Privacy Officer at (314) 994-0209.

I understand I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that this organization is not required to agree to the restrictions requested. I understand I may revoke this consent by contacting Town & Country Pediatrics, PC's Privacy Officer and requesting a Revocation of Consent Form. I understand revoking my consent does not affect disclosures already made in reliance of my prior consent.

This consent is given freely with the understanding that any and all records, whether written, oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as authorized by law. A photocopy or fax of this consent is as valid as the original.

Print Parent's Name

Date

Parent's Signature (or personal representative)

Witness

Date

NOTICE OF PRIVACY PRACTICES

Acknowledgement

I acknowledge that I have received a summary of Town & Country Pediatrics, PC's Notice of Privacy Practices and consent to the use or disclosure of my protected health information by Town & Country Pediatrics, PC for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, to conduct health care operations of Town & Country Pediatrics, PC, and as required by law.

I also acknowledge that I was offered the entire notice and that I understand I may obtain a full version of the notice at any time. I understand my rights as a patient of this practice concerning my Protected Health Information (PHI), as it is outlined in this notice. I am aware Town & Country Pediatrics, PC reserves the right to change the privacy practices that are described in this Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by contacting the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Name of Patient(s)

Signature of Patient or Personal Representative

Relationship to Patient

Date

Town & Country Pediatrics, PC
Care of Infants, Children, and Adolescents
3009 N. Ballas Rd., Suite 141A
Town & Country, MO 63131
Office (314) 994-0209
Fax (314) 994-9130

Due to the new federal privacy regulations, we cannot leave messages with protected health information on home answering machines or with family members without written permission.

Patient(s) name _____

I give **Town & Country Pediatrics, PC** permission to leave messages

_____ On my home answering machine/voice mail.

_____ On my work answering machine/voice mail.

_____ On my cell phone voice mail.

_____ With the persons listed (name and relationship).

Signature

_____ I do not want medical information released except personally to myself.

Signature