2025 PATIENT REGISTRATION

**Today’s Date: Provider:**

***PATIENT INFORMATION***

**Last Name: Frist Name: Middle Name: Date of Birth: Sex: F M Unknown Race: Hispanic: YES NO Address: City: State: Zip: Main Phone: Cell Phone: other:**

**Email:**

**Pharmacy:**

**PARENT INFORMATION**

**Parent/Contact 2** First/Last name: **Relation to Patient**

**DOB: Cell phone: Single Married Divorce**

**Parent/Contact 2** First/Last name: **Relation to Patient**

**DOB: Cell phone: Single Married Divorce**

Emergency Contact Name: Relation: Phone:

**INSURANCE INFORMATION**

**Primary Insurance:**

**Policy ID # Group/Acct#**

Policy Holder Name: Policy Holder SS# D.O.B

**Secondary Insurance:**

**Policy ID # Group/Acct#**

Policy Holder Name: Policy Holder SS# D.O.B

**If parents are divorced or separated, please ﬁll out this Section:**

**Who has custody?** Are there any legal restrictions preventing a non-custodial parent from consenting to or obtaining information about their child's medical treatment? YES / NO

I hereby grant authorization for Summer Pediatrics to provide medical treatment to my child/children. Additionally, I grant permission to release any medical information that may be required to complete insurance forms, school & camp forms, or for other purposes as needed. I authorize the payment for any medical or surgical benefits directly to Summer Pediatrics, which would otherwise be payable to me under the terms of my insurance. In addition, I acknowledge that if any payments are received by me in error from my insurance company, I will reimburse Summer Pediatrics for those payments. I understand that I am responsible for all co-payments and any charges not covered under my insurance benefits. It is my responsibility to inform Summer Pediatrics of any changes to my insurance. Co- payments are due on the date of service. Furthermore, I acknowledge that Summer Pediatrics, LLC has provided me with a copy of its Notice of Privacy Practices, which outlines how they safeguard health- related information and how I can access this information. I have also received a copy of the Vaccination, Refills, Financial, and Office Policies.

**Name**: **Signature: Date:**

FINANCIAL & OFFICE POLICIES

Welcome to Summer Pediatrics. Our staff is dedicated to providing you with the highest quality health care. We hope this information helps you understand how our office operates, as well as your responsibilities during your visits. We kindly ask that you refrain from eating, drinking, or using cellular phones while in our office.

**\_\_\_\_\_Insurance Plans:** It is your responsibility to confirm with your insurance company whether our physician is currently under contract with your plan or if you can access "out of network" benefits. Any questions regarding medical care, well-baby visits, preventive care, lab tests, x-rays, and immunization coverage should be directed to your insurance carrier before your visit. You agree to be responsible for all co-payments, deductibles, and any non-covered services as determined by your insurance plan.

Please remember to bring your child’s insurance card to each appointment. You may also be responsible for additional charges, such as laboratory testing and vision screenings, depending on your coverage. If you change insurance plans, please inform us immediately. If you fail to notify us of any changes in coverage, you will be responsible for paying for the services rendered.

**\_\_\_\_\_Self-Pay:** If I do not have proof of insurance coverage at the time services are rendered, I understand that payment is due at the time of service.

**\_\_\_\_\_Co-payments and any past-due balances** must be paid at the time of check-in. I will ensure I am prepared to make these payments. If someone other than myself will be accompanying the patient(s), payment arrangements will be established. I understand that my account will be charged $30 for insufficient funds or returned checks.

**\_\_\_\_\_Collection Policy:** If we need to refer your account to a collection agency or law firm to collect any unpaid balance, you will be responsible for paying the collection costs in addition to the unpaid balance. If your account is sent to collections, or if you do not pay the outstanding balance or establish a payment plan, we reserve the right to discontinue our services and classify your account as delinquent. In such cases, we will provide you with a medical record release form for your signature, allowing you to transfer your care to a new physician.

**\_\_\_\_\_Service Fees:** You are entitled to one school/camp/daycare form per child per year. Additional forms will require a $10 fee.

**\_\_\_\_\_Medical Records Release:** Written authorization is required to release medical records. The staff will provide you with the form.  Please be aware that $15 per USB drive is charged, and if requested in paper there is a charge of $.65 per page and a $15 administration fee**.**

**\_\_\_\_\_Appointments and Late Arrivals:** We ask that patients arrive on time for their appointments. When patients are late, it becomes difficult to maintain our schedule. If you arrive more than 10 minutes late, you may need to be rescheduled to avoid inconveniencing other patients. Alternatively, you may be seen if the day's schedule allows for it.

**\_\_\_\_\_No Shows & Cancellations Policy:** We expect patients and parents to provide at least 24 hours' notice if they are unable to attend their scheduled appointments. When you confirm an appointment, it means other patientsmiss theopportunity to book that time slot. Additionally, our providers dedicate their time to you, and often, staffing and product orders are arranged based on your appointment.

Please note that if you miss a scheduled appointment, a fee of $50 will be charged. If a family has three missed appointments without notice, they will be automatically discharged from our practice. Thank you for your understanding.

**DIVORCE:** Unfortunately, some of our families experience divorces. We strive to provide support for both the child and the family during this time. However, it is important to note that we serve as the child's advocate and will not involve ourselves in disputes between parents.

Additionally, a divorce does not free parents from their financial responsibilities for their child's medical care. Our policy states that the parent or guardian who brings the child to our office is responsible for payment at the time of the visit, regardless of which parent has the legal obligation to pay for medical care.

**Medication Refill Policy**

Prescription refills may be requested but are only accepted through the portal- Pharmacy requests will be denied. Please allow 48 to 72 hours for all prescription refills.

Be advised, that this is not considered an urgent matter and that certain prescriptions can only be refilled by the prescribing provider, to promote continuity of care. We DO NOT refill medications we have not prescribed.

If this medication is used daily and you do not have any refills left, please notify us at least 1 week before your prescription runs out. We will review your medical record to determine if a follow-up visit or medication adjustment is needed before refilling the prescription. You can also call and speak to one of our nurses if you are unsure if your child needs to be seen. ADD/ADHD Medication Refill Request

A follow-up appointment to review the progress of your child is required every 3 months. We ask the parents to notify our office at least 1 week before the supply runs out, as it may take 3-4 business days for the prescription to be ready. A parent or an authorized representative may pick up the signed prescription, we DO NOT mail prescriptions. If a refill is requested and there has not been a follow-up within the last 3 months, you will be asked to schedule a follow-up visit. Patients must have annual visits to receive Albuterol and Epi-Pen refills.

No further refills will be given until your child has been seen by a provider and is currently on follow-up visits.

Name: Signature: Date:

**Vaccine Policy:** At Summer Pediatrics, we strive to provide comprehensive, family-centered care for all of our patients. We aim to maintain a safe environment where our families receive exceptional medical care compliant with both the American Academy of Pediatrics (AAP) and the Centers for Disease Control (CDC). **Forms/Paperwork**

Please be aware that our office requires seven days to complete any paperwork. We appreciate your understanding and patience as we strive to provide you with the best service possible.

**Our practice strongly believes that a good doctor-patient relationship is built on understanding and open communication. Our staff is committed to addressing any concerns you may have about your account. If you have any questions regarding our policies or need assistance, please don't hesitate to contact us. We are here to help. Revised 11/2024**

Name: Signature: Date: