# South Summit Pediatrics

## Patient Registration

Home Phone ( )_____ Cell ( )_____ Other Phone( )_____

Name_____
First Middle Last

Address_____

City_____State_____Zip_____

Gender _____M_____F Age_____ Birth Date _____/_____/_____
Month Day Year

Mothers Name_____/_____/_____
First Middle Last Birth Date Month Day Year

Fathers Name_____/_____/_____
First Middle Last Birth Date Month Day Year

Guardian's Name _____/_____/_____
First Middle Last Birth Date Month Day Year

### Primary Insurance Information

Policy Holder_____
First Middle Last

Relation to patient_____ Birth date _____/_____/_____ Social Security #_____
Month Day Year

Employer_____Employer Phone_____

Insurance Company _____

Insurance Billing Address_____

Insurance Phone ( )_____

Group #_____ID/Subscriber # _____

### Secondary Insurance Information

Policy Holder_____
First Middle Last

Relation to patient_____ Birth date _____/_____/_____ Social Security#_____
Month Day Year

Employer_____ Employer Phone_____

Insurance Company _____

Insurance Billing Address_____

Insurance Phone ( )_____

Group #_____ ID/Subscriber # _____

***Emergency Contact** _____**Phone**( )_____
(Relationship)

I the undersigned certify that I (or my dependent) have insurance coverage with the above listed insurance company, and assign all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not they are paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions. I agree to pay interest at 1 ½ % per month. If it becomes necessary to refer this account a collection agency, I agree to pay a collection fee of 35% of the principal balance owing. I agree to pay $25.00 for any missed appointments and appointments canceled with less than an hour notice of the appointment time. Further I agree to pay for any and all attorney fees and court costs incurred, should litigation become necessary.

Responsible Party Signature Relationship Date

**HIPAA & Protected Health Information**

By signing this authorization, I acknowledge I have been given a copy of South Summit Pediatrics HIPAA policy and authorize South Summit Pediatrics to use and/or disclose certain protected health information about my child to or for the parties listed below. This authorization permits South Summit Pediatrics to disclose information to the following:

First Last DOB Relationship

First Last DOB Relationship

First Last DOB Relationship

First Last DOB Relationship

Specifically describe the information that you are authorizing to be released to the above named people. (Such as specific dates of service, specific medical conditions, billing information, etc…_____

This authorization will expire on _____ or This authorization has not expiration date unless I decide to revise the list_____