

PEDIATRIC REGISTRATION FORM

Date: _____

Patient Number: _____

PATIENT INFORMATION

First Name	Middle	Last Name	Nickname
Date of Birth	Sex	Social Security Number ()	
Patient Address (Street, Route, Apt. No., Etc.)			Home Phone Number ()
City	State	Zip Code	Cell Phone/Beeper/Pager No. ()
Referring Physician	Primary Care Physician/Pediatrician Name		PCP Office Number

INSURANCE INFORMATION

Primary Insurance Company Name	Policy Number	Group/Plan Number
Insured's Name	Insured's Date of Birth	Relationship to Patient
Secondary Insurance Company Name	Policy Number	Group/Plan Number
Insured's Name	Insured's Date of Birth	Relationship to Patient

PARENT/GUARDIAN INFORMATION

Mother's Information	Father's Information
Name	Name
Mother's SS # DOB	Father's SS # DOB
Spouse's Name	Spouse's Name
Address City, ST, Zip	Address City, ST, Zip
Home Phone Number () Cell/Pager Number ()	Home Phone Number () Cell/Pager Number ()
Employer Name Work Phone Number ()	Employer Name Work Phone Number ()

Insurance:

In order to comply with your insurance **all copayments, co-insurance, deductible and/or non-covered services must be paid at the time service is rendered.** Please remember that insurance is considered only a method of reimbursement to the physician for services you have received – making you ultimately responsible. If there are any questions regarding the payment or insurance filing policies, please see one of the office staff at this time to make any necessary arrangements. Regardless of custody arrangements or divorce decrees, the person bringing a dependent in for services is responsible for all copayments, etc., and is expected to pay at the time service is rendered.

You are responsible for obtaining a referral if one is required by your insurance carrier. If we are participating providers with your carrier, we will file your claim for your office visit or surgery and allow 45 days for payment in full. Should payment not be received within 45 days, the balance due will become the obligation of the guarantor on the account and must be paid within 30 days. If you do not have insurance, or we are not a participating provider with your insurance carrier, payment is expected today for services rendered.

Agreement to Pay:

The undersigned responsible party does hereby agree to pay for all services rendered to the above-named patient. The undersigned accepts the fee charged as a lawful debt and promises to pay said fee including all costs of collection, attorney fees, and court costs, if such be necessary, waiving now and forever the right to claim exemption under the constitution and laws of the State of Alabama or any other state. All unpaid balances will be charged a 1.5 percent rebilling fee monthly. All returned items will be assessed a \$25.00 fee.

Consent to Treat:

I hereby consent to the treatment for the above listed child as the parent or legal guardian of the patient. I further understand that prior to services being rendered; I must submit in writing my approval for anyone else to bring this child for services such as a grandparent and/or other relatives.

Health Insurance Portability and Accountability Act (HIPAA):

I consent to the use or disclosure of my protected health information (PHI) by Alabama Ophthalmology Associates, P.C. (the Company) for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations.

My PHI means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This PHI relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review the Company's Notice of Privacy Practices (the Notice) prior to signing this document. I have received a copy of the Company's Notice. The Notice describes the types of uses and disclosures of my PHI that will occur in my treatment, payment of my bills or in the performance of health care operations of the Company. The Notice for the Company is also provided in the main lobby of the practice and on the Company's website at www.aoapc.com. This Notice also describes my rights and the Company's duties with respect to my PHI.

The Company reserves the right to change the privacy practices that are described in the Notice. I may obtain a revised notice of privacy practices by accessing the Company's website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Mother's/Guardian's Signature and Date

Father's/Guardian's Signature and Date



TLC Pediatrics L.L.C.

CONSENT FOR TREATMENT OF A MINOR

I, The parent or guardian of said patient, who i.e. a minor, authorize TLC Pediatrics and all persons acting as agents thereof and all physicians to whom said minor is referred for medical treatment, to furnish all forms of diagnostic, preventative and medical treatment to said minor. This consent shall remain in effect until a written revocation hereof is delivered to TLC Pediatrics LLC.

AUTHORIZATION AND RELEASE

I authorize TLC pediatrics LLC to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to TLC Pediatrics LLC insurance benefits otherwise payable to me.

PAYMENT POLICY

I understand that if TLC Pediatrics LLC is not contracted with my insurance carrier, I must pay in full at the time of service. I understand that my insurance carrier may pay less than the actual bill for services. I also understand that some services provided by TLC Pediatrics LLC may not be covered by my benefit plan. I agree to be responsible for payment of all services rendered.

I understand that all Co-payments, Co-insurance and Deductibles are due at the time of service. I understand that any balance generated is due within 10 days of the billing day. I realize that failure to keep this account current may result in TLC Pediatrics LLC being unable to provide additional services.

In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect this amount or any future outstanding balances.

I HAVE READ AND UNDERSTAND THE INFORMATION ON THIS FORM, NAMELY THE SECTIONS TILTLED: CONSENT TO TREATMENT OF A MINOR, AUTHORIZATION AND RELEASE AND PAYMENT POLICY. I AM THE PARENT OF SAID MINOR CHILD, OR THE COURT-APPOINTED GUARDIAN FOR THE PATIENT AND I AM AUTHORIZED TO ACT ON THE PATIENT’S BEHALF TO SIGN THIS RELEASE OF INFORMATION.

SIGNATURE OF PARENT OR GUARDIAN OF PATIENT

DATE

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