MERCER ISLAND PEDIATRICS, INC. P.S.

REGISTRATION FORM

Today's Date: **Physician:**

PATIENT INFORMATION

Patient's Last Name:	First:	MI:	Birth Date:	Sex:	Patient's Phone #:

Street Address:	SSN:	Home Phone:
City:	State:	ZIP:

Sibling Names & DOB: **PREFERRED METHOD OF CONTACT:**

PARENT INFORMATION

PARENT #1			PARENT #2		
Last Name: First Name: DOB:			Last Name: First Name: DOB:		
Address (if different from patient):			Address (if different from patient):		
Send bills to this address? ☐ Yes ☐ No			Send bills to this address? ☐ Yes ☐ No		
Home Phone:	Work Phone:	Cell Phone:	Home Phone:	Work Phone:	Cell Phone:
Employer:	Occupation:		Employer:	Occupation:	
Email Address:			Email Address:		
Relationship to Patient:			Relationship to Patient:		

HOW DID YOU HEAR ABOUT MERCER ISLAND PEDIATRICS?

EMAIL ADDRESS FOR THE PATIENT PORTAL:

INSURANCE INFORMATION

Primary Insurance:	Group Number:	Policy Number:	Co-Payment:

Subscriber's Name:	Subscriber's SSN:	Subscriber's DOB:

Patient's Relationship to Subscriber: ☐ Self ☐ Child ☐ Other_____

Secondary Insurance:	Group Number:	Policy Number:	Co-Payment:

Subscriber's Name:	Subscriber's SSN:	Subscriber's DOB:

Patient's Relationship to Subscriber: ☐ Self ☐ Child ☐ Other_____

EMERGENCY CONTACTS

Name of Local Friend or Relative (not living at same address):	Relationship to Patient:

Phone Numbers: [Home] [Work] [Cell]

THE ABOVE INFORMATION IS TRUE AND TO THE BEST OF MY KNOWLEDGE. (Please sign and date below)

_____	_____	_____
Printed Name	Signature	Relationship to Patient

PEDIATRIC PATIENT QUESTIONNAIRE

Patient's Name: _____ Date of Birth: _____
Siblings Name: _____ Date of Birth: _____

Past Medical History

Allergies (Medication, Food, Insects, Etc.): _____
Medications/Supplements: _____
Problems during Mom's pregnancy, the birth or newborn period _____
Hospitalizations/Surgeries: _____
Current or past medical problems: _____

Please check any of the following:

o Vision problems
o Hearing problems
o Speech problems
o Poisoning/ overdose
o Serious accident
o Motor delays
o Learning problems
o Mental health concerns
o Concussion/ serious head injury
o Hay fever or asthma
o Urinary tract infection
o Constipation
o Soiling
o Anemia
o Heart murmur

Briefly explain the above concerns; or add any additional information you feel is important about your child's health:

_____

_____

Family History

Has anyone in the patient's family had any of the following?

o Child is adopted
o Birth defects/malformations
o Developmental problems
o High cholesterol
o Hip problems at birth
o Anemia or blood disorder
o Asthma or wheezing
o Tuberculosis
o Seizures
o Death before 1 year of age
o Diabetes
o Vision
o Hearing Loss
o Learning problems
o School problems
o Eating disorder
o Mental illness
o Suicide
o Alcoholism
o Substance abuse
o Cancer
o Migraine headaches
o Kidney problems
o Emotional problems
o Depression
o Heart disease or stroke
o Hyperactivity or attention deficit disorder

Today's Date: _____ Parent/Guardian Signature: _____

Mercer Island Pediatrics Financial Policies

1**. Patient Information/Proof of Insurance**: At each visit, please be prepared to present your insurance card as proof of insurance***. If you fail to provide us with your child's correct insurance information, you will be responsible for payment of services rendered*****.**

2. **Insurance**: We participate with most insurance plans and will submit a claim to your insurance company on your behalf. ***If you are not insured or not insured by a plan with which we are contracted, payment in full is expected at time of service***. If we are a participating provider with your plan, but you do not have an up-to-date insurance information, payment in full is required at time of service. ***Knowing your insurance benefits and rules is your responsibility***. Please contact your insurance plan with any questions you may have regarding your coverage.

3. **Newborn Coverage**: Most insurance companies will cover your newborn up to 30 days from the date of birth. It is important to enroll your newborn in your plan during this time. If your newborn is not on your plan after 30 days, we will expect payment at time of service.

4. **Co-payments and deductibles**: This arrangement is part of your contract with your insurance company. ***Co-payments must be paid at the time of service***.

5. **Non-covered services**: Our providers follow appropriate medical guidelines for standard of care based on your medical condition. Please be aware that some of the services you receive may be determined by your insurance plan to be only partially covered or not covered. ***You will be financially responsible for the cost of services that are not paid.***

6. **Coverage changes**: If your insurance changes, please notify us before your next visit. Failure to notify us of insurance changes could result in denial of claims and patient responsibility for payment of the denied claim.

7. **Claims submission**: Your insurance benefit is a contract between you and your insurance company. We will submit your claims for the services which have been provided. Your insurance company may need you to supply certain information directly to process a claim. It is your responsibility to comply with their request. ***Please be aware that the balance of your claim is your responsibility whether your insurance company pays your claim*****.**

8. **Missed and no-show appointments**: If you arrive late for your appointment, you may be asked to reschedule for another day. ***You will be charged a fee of $50 for missed appointments not canceled within 24-hours of your scheduled appointment and for no-shows***. These charges will be your responsibility and must be paid before being scheduled for another appointment. We reserve the right to dismiss patients from our practice who frequently miss appointments without giving 24-hours notice.

9. **Forms and Letters**: You will be charged a fee of $15 for the physician to complete all sports, camp, school forms and letters and a $40 fee for immediate request.

10. **After-hours**: You will be charges a $25 fee each time you speak with an after-hours RN through our answering service.

11. **Medical records**: You will be charged a fee of $1.24 for the first 30 pages and 0.94 cents per page for all other pages for copies of medical records and may be subject to a clerical fee of $28 for searching and handling records; however, we will provide a copy of your child's immunization records at no charge.

12. **Divorce/Separation**: In cases of divorce and/or separation, the legal guardian and/or ***the person bringing the child in for services will be held responsible for paying any balance*** originating from that visit. If you provide legal documentation that someone other than the legal guardian is financially responsible and you provide billing information for that responsible party, we will attempt to bill that party. However, if the balance is unpaid by that person, you will be held responsible for the balance on your child's account.

13. **Refunds**: If you have overpaid your account, a refund check will be mailed to the patient or guarantor.

14. **Past due balances**: Past due balances of 90 days and over will be sent to a collection agency. If an unpaid balance is sent to a collection agency, payment will need to be made directly to the agency. Once an account is deemed uncollectible by MIP, then it will be necessary to pay for each visit at the time of check in regardless of whether you have insurance.

15. **Stat lab fees**: If the physician determines that your child's lab test needs to be processed immediately by Seattle Children's Hospital, you will be charged a fee of $35 for the specimen transport. If you would like to decline stat lab processing, please inform the physician at the time of your child's collection.

I acknowledge receipt of Mercer Island Pediatrics Financial Policies

Patient's Name: _____ Date of Birth: _____

Parent/Legal Guardian Signature: _____ Today's Date: _____

Mercer Island Pediatrics

Notice of Privacy Practices – Acknowledgement

We keep record of the healthcare services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless the law authorizes or compels us to do so. You may see your record or get more information about it by contracting Mercer Island Pediatrics.

If you request our providers to compete a form for school, sports, camp, etc., you are giving us consent to provide medical information.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed and how you can access your information. This form will be retained in the patient's medical record.

Patient Agreement

Assignment of Insurance Benefits hereby authorize Mercer Island Pediatrics to request and directly collect, on my behalf, all public and private insurance coverage benefits due for products and services provided by Mercer Island Pediatrics. If insurance benefits are paid directly to me, I will endorse these checks for such payments to Mercer Island Pediatrics.

Medical Consent to all routine, usual, and customary patient tests, procedures, and exams performed or prescribed by the physicians of Mercer Island Pediatrics.

Release of Medical Information authorize Mercer Island Pediatrics to release any healthcare information necessary to facilitate the processing of insurance claims and audits of payments relative to the services provided to patient by Mercer Island Pediatrics.

A special Consent for Release of Confidential Information must be signed for those patients' receiving services related to HIV/AIDS. Mercer Island Pediatrics will keep a record of the healthcare services provided to patient. I may see that record and copy it. Mercer Island Pediatrics will not disclose my record to others unless I direct Mercer Island Pediatrics to do so, or unless the law authorizes them to do so.

THE PATIENT/GUARANTOR AGREES THAT HE/SHE IS HEREBY FINANCIALLY RESPONSIBLE FOR ALL CHARGES INCURRED FOR SERVICES PROVIDED INCLUDING THOSE THAT MY NOT BE COVERED BY YOUR INSURANCE. THESE MAY INCLUDE FEES FOR MEDICAL SUPPLIES, AFTER-HOURS AND EMERGENCY OFFICE VISITS, HOME VISITS AND AFTER-HOURS PHONE CALL CHARGES.

A duplicate copy of this Patient Agreement shall be considered the same as the Original.

I acknowledge receipt of this notice

Patient's Name Printed: _____ Date of Birth: _____

Patent/Guardian Signature: _____ Today's Date: _____