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:					

PARENT INFORMATION

PARENT #1			PARENT #2		
Last Name: First Name: MI:			Last Name: First Name: MI:		
Address (if different from patient): Send bills to this address? ❑ Yes ❑ No			Address (if different from patient): 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:	DOB:		Relationship to Patient:	DOB:	

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 to the best of my knowledge. (Please sign and date below)

Signature/Date	Name	Relationship to Patient

Revised 6/24/2015

Mercer Island Pediatrics, Inc. P.S.

PEDIATRIC PATIENT QUESTIONNAIRE

Today's Date: ________________

Patient's Name ______________________________DOB ______________________________

Siblings: DOB: Health:

____

____

____

Past Medical History

Allergies to medications, food or insects ______________________________

Medication taken regularly ______________________________

Problems during Mom's pregnancy, the birth or newborn period ______________________________

Hospitalizations ______________________________

Surgeries ______________________________

Serious illness or medical problems ______________________________

Please check any of the following your child has had:

- 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 Urine infections
- o Constipation
- o Soiling
- o Anemia
- o Heart murmur

Briefly explain the above concerns:

____

____

____

Family History

Please check any of the following conditions that any close blood relative or your child has had:

- o Child is adopted
- o Birth defects/malformations
- o Mental retardations
- o High cholesterol
- o Anemia or blood disorder
- o Asthma or wheezing
- o Tuberculosis
- o Hyperactivity or attention deficit disorder
- o Death before 1 year of age
- o Diabetes
- o Vision or hearing loss
- o Hip problems at birth
- o Eating disorder
- o Mental illness/suicide
- o Seizures
- o Alcoholism/substance abuse
- o Cancer
- o Migraine headaches
- o Learning problems/school problems
- o Kidney problems
- o Emotional problems/depression
- o Heart attack or stroke by age 50

Comments (more room on back)

____

____

Julie Ellner, MD, FAAP
Danette Glassy, MD, FAAP
Luz María González, MD, FAAP
Hal C. Quinn, MD, FAAP
John Schreuder, MD, FAAP

Mercer Island Pediatrics

9675 SE 36th St., Ste. 100
Mercer Island, WA 98040
phone 206.275.2122
fax 206.275.0860
www.mipediatrics.com

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 in a timely manner, you will be responsible for payment of services rendered.**

2. Insurance: We participate in most insurance plans and are happy to 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 each visit.** If we are a participating provider with your plan, but you do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. **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 that you enroll your newborn in your plan during this time. If your newborn is not on your plan after 30 days, we will expect payment in full at each visit until your child is enrolled.

4. Co-payments and deductibles: **Co-payments must be paid at the time of service**. This arrangement is part of your contract with your insurance company. A processing fee will be added to your account if your copay is not paid when checking in for your appointment.

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 to help you receive your maximum benefits. 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 in order 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 or not 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. **Our policy is to charge for missed appointments** not canceled within 24-hours of your scheduled appointment and for no-show appointments. 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: There will be a charge for the physician to complete all sports, camp and school forms.

10. After-hours: We charge a fee each time you speak with an after-hours RN through our answering service.

11. Medical records: We are happy to provide a copy of your child's immunization records to you at no charge; however, there is a charge for copies of medical records whether for yourself or another physician's office.

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: In the event that you have overpaid your account, a refund check will be mailed to the patient or guarantor.

If you have any questions, please call our Billing Office at 206-275-2122 x 114.

I acknowledge receipt of Mercer Island Pediatrics Financial Policies:

______________________________ ______________________________

Parent/Guardian Signature Date

______________________________ ______________________________

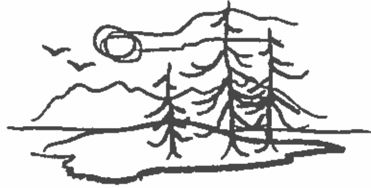
Print Name Child's Name

____

Child's Name

____

Child's Name



Mercer Island Pediatrics

9675 SE 36th Street, Suite 100
Mercer Island, WA 98040

Tel: 206-275-2122
Fax: 206-275-0860

PATIENT AGREEMENT

Assignment of Insurance Benefits:

I 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:

I 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:

I 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.

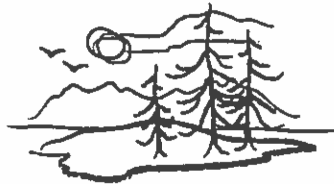
A duplicate copy of this Patient Agreement shall be considered the same as the Original.

____________________________ ________________________

Signature of Patient/Guarantor **Date**

____

Printed Name of Patient



Mercer Island Pediatrics

9675 SE 36th St., Suite 100
Mercer Island, WA 98040

Tel: 206-275-2122
Fax: 206-275-0860

NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGEMENT

We keep a 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 you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting the Mercer Island Pediatrics Privacy Officer.

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 patient's medical record.

I acknowledge receipt of this notice.

______________________________ Date: ____________________
Patient or legally authorized individual

______________________________ ________________________
Printed Name of Patient Relationship(parent, legal guardian)