Macomb Pediatric Associates, P.C. Patient Registration and Annual Update

All Patients:

1. First Name: _____ MI: ____ Last: _____ DOB: _____ M OR F
2. First Name: _____ MI: ____ Last: _____ DOB: _____ M OR F
3. First Name: _____ MI: ____ Last: _____ DOB: _____ M OR F
4. First Name: _____ MI: ____ Last: _____ DOB: _____ M OR F
5. First Name: _____ MI: ____ Last: _____ DOB: _____ M OR F
6. First Name: _____ MI: ____ Last: _____ DOB: _____ M OR F

Race: Asian Black/African American Indian White/Caucasian Other_____ Decline to Specify

Patient(s) Address: _____

City: _____ State: _____ Zip Code: _____

*Responsible Party for Statements: _____ Address: _____

*City: _____ State: _____ Zip Code: _____ ☐ Check if same as above

Guarantor/Responsible Party(s) ***Custody Papers are REQUIRED, if Guarantor is not a parent:***

Mother's Name: _____ Phone Number: _____

Father's Name: _____ Phone Number: _____

Other's Name: _____ Phone Number: _____

Emergency Contact/other than a parent: _____ Relationship: _____ Phone Number: _____

Pharmacy Name: _____ Phone Number: _____ Cross Roads: _____

Private Insurance Name: _____ All Children [_] or Only for: _____

Contract or ID #: _____ Group # : _____ Effective Date: _____

Subscriber Name: _____ Subscriber DOB: _____ Subscriber S.S. # _____

Employer: _____ Work Phone #: _____ PCP: _____

Secondary Insurance Name: _____ All Children [_] or Only for: _____

Contract or ID #: _____ Group # : _____ Effective Date: _____

Subscriber Name: _____ Subscriber DOB: _____ Subscriber S.S. # _____

Employer: _____ Work Phone #: _____ PCP: _____

Medicaid Insurance Name: _____ All Children [_] or Only for: _____

Contract or Member ID: 1._____ 2._____ 3._____

4._____ 5._____ 6._____

---OFFICE USE ONLY BELOW---

DATE: _____

[__] NEW PATIENT [__] NEW INSURANCE [__] NEW ADDRESS/PHONE [__] UPDATE ONLY [__] FAXED TO BILLING

[__] NEW PATIENT & FAMILY HAS EXISTING ACCT #: _____ **Please read, initial and sign the back →**

( )Check here if ADULT PT

Authorization to Release Information/Assign Benefits

I authorize the release of any medical information necessary to process any claims. I hereby authorize my insurance benefits to be paid directly to the providers of Macomb Pediatric Associates, P.C. Initial: _____

I understand that I am financially responsible for non-covered services. I certify that the information I have reported with regard to my insurance is correct. I permit a copy of this authorization to be used in place of the original. Initial: _____

Financial Agreement for Payment of Medical Services

I understand insurance claims are filed as a courtesy to me. It is my responsibility to know any deductibles, copays, or non-paid services. There is no liability to Macomb Pediatric Associates, P.C. as to guarantee of payment. ALL COPAYS AND OUTSTANDING BALANCES ARE TO BE PAID AT THE TIME OF SERVICE. Any amount not covered by my insurance is to be promptly remitted. Initial: _____

The Policy of Macomb Pediatric Associates, P.C. is as follows:

1. Any adult that brings minor child or children in for treatment is responsible for paying any and all copays and/or previous balances due.
2. It is to my understanding that all financial matters are kept in confidentiality by Macomb Pediatric Associates, P.C.
3. We do not get involved in legal disputes between custodial parents.
4. There is a 5% service fee on all unpaid balances 30 days overdue.
5. There is a $35 fee per returned check, due to insufficient funds.
6. There is a $25 fee per NO SHOW on all appointments. There is a maximum allowance of 3 no shows per family, then the family account will be reviewed for possible dismissal from our practice. A no show is a cancellation without 24 hour prior notice or being late for an appointment by 15 minutes or more, per the MPA office policy.
7. Medical Record Release fees will apply according to the State Of Michigan Medical Records Access Act.
8. To ensure Confidentiality and privacy, any type of electronic recording is strictly prohibited at any location within these offices. Thank you for your understanding and compliance.

Signature: _____ Date: _____

----------OFFICE USE ONLY BELOW----------

No Changes: _____ As Of: _____