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

Clearly Print __All Patients__ that come here:

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 (circle): Asian Black/African American Indian White/Caucasian Other:________ Decline to Specify

Patient(s) Address:______________________________

City:______________________ State:________ Zip Code:__________

Billing Address for Statements: [ ] Same address as above **OR** [ ] Mail to Guarantor(s) Name(s): ______________

@ Address:______________ City:__________ State:_____ Zip Code:________

Guarantor(s) Please circle Relation to Patient(s): ***Legal Guardian Papers are REQUIRED** [__] **Copy in Chart**

Mother / *Guardian #1 Name:______________________ Ph #:__________

Father / *Guardian #2 Name:______________________ Ph #:__________

Adult Patient's Name (if applicable):______________________ Ph #__________

Emergency Contact-Other than the above named:__________ Relation to Patient:________ Ph #:__________

~ Pharmacy Name:__________ Phone #:__________ Cross Roads:__________

Private Insurance Company Name:______________________ All Children [_] or Only for:________

Contract ID #:______________ Group #:__________ Effective Date:________

Subscriber Name:______________ Subscriber DOB:__________ Subscriber S.S. #:________

Employer:______________ Work Phone #:__________ PCP:________

Secondary Insurance Company Name:______________________ All Children [_] or Only for:________

Contract ID #:______________ Group #:__________ Effective Date:________

Subscriber Name:______________ Subscriber DOB:__________ Subscriber S.S. #:________

Employer:______________ Work Phone #:__________ PCP:________

MEDICAID Insurance Company Name:______________________ All Children [_] or Only for:________

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

4.__________ 5.__________ 6.__________

Insurance Card & ID Required

Guarantor MUST read, initial and sign the back →

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

[__] NEW PATIENT; If Family has Acct#__________. [__] NEW INSURANCE [__] NEW ADDRESS/PH [__] FAXED TO BILLING

[__] ADULT PATIENT [__] **ID Copied** [__] **Insurance Card Copied** **MPA Initials:**______

DATE:__________

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 resposible 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 quarantee 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. (MPA) is as follows:

1. Any adult that brings minor child or children in for treatment is resonsible for paying 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 $50 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.
7. MPA requires 24-hour prior notice for cancellation or reschedule of all appointments.
8. There is a $25 fee for all cancellation and reschedule within one hour of appointment time.
9. Appointment arrivals past the scheduled appointment time may result in the need to be rescheduled. We do not guarantee a "grace period" and cannot honor all late appointments.
10. Medical Record Release fees will apply according to the State of Michigan Medical Records Access Act.
11. 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.
12. **I understand that I must provide my identification and all insurance cards, to be copied by MPA.**
13. **My signature below means that I understand and agree with all information on this document.**

Signature: ______________________________ **Date:** ______________

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

Signature for NO Changes: ______________________ Updated Date: ______________

MPA Initials: ________