Collins Pediatrics

Patient Registration & Consent Form

*Please complete one registration and consent form for **each individual patient**. For registration and billing purposes, please be sure to fill forms out completely. This is to ensure all families will be linked in our records correctly.*

◯ **New Patient** ◯ **Existing Patient**

Patient Information

First Name_____

Last Name_____

Patient Nickname_____

Date of Birth_____

Primary Phone_____
*the primary number is what will be used to confirm appointments

Address_____

City_____State_____Zip_____

Ethnicity- Required by Louisiana Immunization Network for Kids Statewide Known as LINKS (***CIRCLE ONE***):

American Indian or Alaskan Native **Asian**

Caucasian **Black or African American**

Hawaiian Native or Pacific Islander **Hispanic**

Other

List ALL Children in this Family INCLUDING Patient

Name (first and last**)** **DOB** **Circle One**

_____**M / F**

_____**M / F**

_____**M / F**

_____**M / F**

_____**M / F**

_____**M / F**

Insurance Information

Insurance Carrier_____

Policy Holder's Name_____

Policy Holder's SSN_____

ID/Policy/Member #_____

Group #_____

Relationship to Patient_____

Referred By:_____

Please enter financially responsible parent first. This is for our billing and registration purposes

#1 Parent/Guardian Information

◯ **Mother** ◯ **Father** ◯ **Other**_____

First Name_____

Last Name_____

Address_____

City_____State_____Zip_____

Cell _____Work _____

Date of Birth_____

Employer_____

Primary Email_____

#2 Parent/Guardian Information

◯ **Mother** ◯ **Father** ◯ **Other**_____

First Name_____

Last Name_____

Address_____

City_____State_____Zip_____

Cell _____Work _____

Date of Birth_____

Employer_____

Primary Email_____

Emergency Contact (Other than Guardian)

(This is anyone who will be bringing child in, calling with nurse questions or making appts for patient)

First Name_____

Last Name_____

Cell Ph_____Work Ph_____

Relationship to Patient_____

A photocopy or scan of this authorization shall be considered as effective and valid as the original.

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Patient Information

First Name_____

Last Name_____

Date of Birth_____

Consent to treat minor (under 18) in absence of a parent

I hereby authorize Collins Pediatrics to render medical treatment to my child(ren) in my absence when he/she is brought in by any other person other than myself.

Signature of parent/guardian_____

Date_____

Consent to treat patient (18 & older) in absence of parent

I hereby authorize Collins Pediatrics to render medical treatment to my child(ren) in my absence when he/she comes in alone without myself or any other guardian.

Signature of parent/guardian_____

Date_____

Release of Information to Insurance Company

By signing below, I authorize Collins Pediatrics to furnish all necessary information to my insurance carrier(s) concerning my child's medical care and treatment. I also irrevocably assign to the doctor and/or nurse practitioner all insurance payments for medical services rendered and all major medical benefits.

Signature of parent/guardian_____

Date_____

Responsibility for Payment of Medical Services

I understand that I am personally obligated to pay for all medical services rendered, regardless of whether or how much my insurance company has paid.

I understand that if insurance is denied due to lack of information, I am responsible for getting the insurance company the necessary information or I am responsible to pay the current balance in full.

I understand that if my insurance company does not pay a claim for any reason, I am responsible to pay the current balance in full.

I understand that after my insurance company pays for a claim, I am responsible to pay any remaining balance in full.

I understand that if I do not have insurance coverage, I am responsible to pay the current balance in full.

I understand that all co-pays are due at the time of visit.

I understand that when I receive any bill in the mail, I am responsible to pay the amount in full.

Signature of parent/guardian_____

Date_____

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