Sunshine Pediatrics, LLC

PATIENT REGISTRATION and ACKNOWLEDGEMENT OF OFFICE POLICIES

DATE: _____

PATIENT INFORMATION

LAST NAME: _____ FIRST: _____MI: _____

DOB: ____/___/_____ GENDER: ___M __ F RACE/ETHNICITY: _____

ADDRESS: _____

STREET APARTMENT# CITY STATE ZIP CODE

MOTHER'S NAME: _____ DOB: __/__/__ PHONE# _____

FATHER'S NAME: _____DOB: _/__/___PHONE#_____

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RESPONSIBLE PARTY/GUARANTOR (THE PERSON FINANCIALLY RESPONSIBLE FOR PAYING CHARGES NOT COVERED BY INSURANCE)

LAST NAME: _____ FIRST: _____ MI: _____

DOB: ____/____/_____ SSN#: _____-_____-_____

PHONE (H): _____WORK: _____EXT: _____ CELL: _____

ADDRESS: (if different from above): _____

E-MAIL ADDRESS (for patient portal and telemedicine appointments):

_____

PREFERRED PHARMACY: _____ PHONE#: _____

ADDRESS: _____

STREET CITY STATE ZIP CODE

EMERGENCY CONTACT INFORMATION (AN ADULT OTHER THAN PARENTS OR GUARDIANS)

LAST NAME: _____FIRST: _____RELATION TO PATIENT: _____

PHONE (H): _____ WORK: _____ EXT: ___ CELL: _____

HEALTH INSURANCE INFORMATION

PRIMARY INSURANCE INFORMATION

INSURANCE CO. NAME: _____ ID/POLICY #: _____

INSURED'S NAME: _____ RELATIONSHIP TO PATIENT: _____

EFFECTIVE DATE OF PRIMARY INSURANCE POLICY: _____/____/_____

SECONDARY INSURANCE INFORMATION

INSURANCE CO. NAME: _____ID/POLICY #: _____

INSURED'S NAME: _____ RELATIONSHIP TO PATIENT: _____

EFFECTIVE DATE OF SECONDARY INSURANCE POLICY: __/___/____

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AUTHORIZATION TO ASSIGN INSURANCE BENEFITS AND TO RELEASE PERSONAL HEALTH INFORMATION(PHI).

I hereby authorize, assign, and release directly to DR. MAIYA Y. E. CLARK AND SUNSHINE PEDIATRICS, LLC all insurance benefits otherwise payable to me for medical treatment, services and supplies rendered or furnished to me or the above-named patient/dependent by DR. CLARK AND SUNSHINE PEDIATRICS, LLC. I agree to be responsible for any amount of medical treatment, services and supplies not covered or payable by the insurance company, or for the full amount of medical and supply charges if the above-named patient does not have or is not covered by insurance. If payment is not received from the insurance company within SIXTY (60) DAYS of filing the claim, I agree that payment becomes my responsibility**.** In order to verify the patient's insurance coverage, I understand that a currently valid insurance card for the patient must be presented at each and every visit. Moreover, I fully understand my responsibility to promptly NOTIFY my insurance company that Dr. MAIYA Y. E. CLARK is to be designated the patient's "Primary Care Provider" (PCP) in order to secure the benefits of my policy. **If she is not formally designated as PCP, we cannot file your insurance claim and you understand and acknowledge that you will become personally responsible for the full amount of charges incurred for the visit at the time of service.**

INITIAL _____

I authorize DR. CLARK AND SUNSHINE PEDIATRICS, LLC to release any Personal Health Information (PHI) needed to process and secure payment of the insurance claim. **INITIAL** _____

I hereby certify that the information I have provided regarding the patient and the above-referenced insurance coverage is current and correct and I will promptly notify SUNSHINE PEDIATRICS, LLC of any subsequent changes to the status of such coverage or insurance. I agree and permit a copy of this authorization to be used in place of the original. **INITIAL** _____

AUTHORIZATION FOR TREATMENT AND FINANCIAL RESPONSIBILITY

I hereby authorize and grant permission to any of the Practice doctors, nurse practitioners, or their designated alternates, to take necessary medical action in emergency situations for my child when I am not immediately available**.** **INITIAL** _____

SUNSHINE PEDIATRICS, LLC and its clinical staff follow the guidelines for preventative care, immunizations and routine lab tests set by the American Academy of Pediatrics. You may become responsible for partial or full payment of some or all of these procedures depending on your insurance coverage. Parents and guardians of the patient are responsible for knowing and understanding what their insurance policy does and does not cover prior to the patient's visit. Any problems or disputes

regarding the extent of coverage or payment of benefits should be settled by the parent or guardian directly with their insurance carrier**.** **INITIAL _____**

I acknowledge and understand that payment for medical charges is required at each visit prior to being seen by the provider, and that I am personally responsible for payment of all services rendered and any outstanding patient balances. Further, I agree to pay any and all co-payments, co-insurance, and/or deductibles required by my insurance policy at the time of each visit.

INITIAL _____

APPOINTMENTS POLICY

Office visits at SUNSHINE PEDIATRICS, LLC are by appointment only. **NO WALK-INS WILL BE SEEN**. **There is a 10-minute grace period for all physical appointments. However, there is no grace period for scheduled same day sick appointments.** A parent, legal guardian or authorized proxy must accompany a child younger than 18 years of age to each visit in order to provide legal consent for all medical treatment and services provided by the Practice.

Please add the patient's appointment to your calendar upon scheduling it. We will attempt to send you a reminder of the appointment by phone, text, or email, but you bear the ultimate responsibility to timely honor and keep the appointment. Missed appointments and untimely cancellations represent a cost to the Practice, to you and to other patients who could have been seen during the time set aside for you. If you must cancel an appointment, you must give the office at least 24 hours advance notice or you will be charged a $25 missed appointment fee. Such fee is not covered by insurance and must be paid prior to your next appointment. More than 3 missed appointments may result in being discharged from the Practice. **INITIAL _____**

ADMINISTRATIVE FEES

There is a $15.00 fee charged for each school, daycare or camp health assessment form completed by the office, $20 fee for FMLA forms and a $20.00 fee for each letter written at your request**.** **INITIAL_____**

PARENTAL/GUARDIAN SEPARATION OR DIVORCE

SUNSHINE PEDIATRICS, LLC does not get involved in disputes between separated or divorced parents/ guardians and the particulars of their legal agreements regarding financial responsibility for their child's medical expenses. The parent or guardian who brings the patient/child in for medical treatment is the person responsible for the charges. We will provide a receipt so that the party paying for the medical services can seek reimbursement from the other parent/guardian. This office will not bill third parties for the payment of the balance due on the date of service**. INITIAL _____**

SELF PAY PATIENTS

Full payment is due at the time of service unless alternate financial arrangement has been made in advance. Under the "Pay Out of Pocket" provisions in HIPPA, an otherwise insured patient has the right to pay out of pocket and not have the services reported to his insurance company on a case-by-case date of service basis. We cannot, however, submit some of the service charges to insurance and accept payment out of pocket for other portions of service charges incurred on the same day**.**

INITIAL _____

REFUNDS

Any overpayments on a patient's account will be refunded within thirty (30) days of the time it is determined by the insurance company and offset by any prior outstanding patient balance.

INITIAL _____

ACKNOWLEDGEMENT OF REVIEW OF THE NOTICE OF PRIVACY PRACTICES

I have had the opportunity to carefully review the Notice of Privacy Practices for Sunshine Pediatrics, LLC. This notice explains how the patient's personal health information may be used and disclosed by the office and how you can get access to this information. You are entitled to a copy of this document upon request. **INITIAL _____**

ACKNOWLEDGEMENT OF RECEIPT OF OFFICE POLICIES AND PROCEDURES

I acknowledge and certify that I received, carefully reviewed, and understood this and any accompanying information regarding the office's policies and procedures. I will comply with these policies and procedures as written. **INITIAL_____**

I have read, agreed to, and fully understand the policies and conditions set forth above and acknowledge my personal responsibility for the payment of this patient's account.

PATIENT NAME: (please print): _____

_____ DATE: _____ RELATIONSHIP TO PATIENT_____

SIGNATURE/ACKNOWLEDGEMENT OF PARENT OR GUARDIAN FILLING-IN FORM

_____ DATE: __/__/_____ RELATIONSHIP TO PATIENT: _____

SIGNATURE/ACKNOWLEDGEMENT OF GUARANTOR OF PAYMENT/RESPONSIBLE PARTY