KNOXVILLE PEDIATRIC ASSOCIATES, P.C.

18 YEAR OLD >REGISTRATION FORM

(Please Print)

Today's date:					
PATIENT INFORMATION					
Patient's last name: First: Middle:					Preferred Name:
Is this your legal name? ❑ Yes ❑ No	Birth date: / /	Social Security Number:	Age:		Sex: ❑ M ❑ F
Street address:		Email Address:			Phone no.: ( )
P.O. Box:	City:		State:		ZIP Code:
Occupation:	Employer:				Employer phone no.: ( )
Race:	Ethnicity: (circle one) Hispanic Non-Hispanic				
If Student, please list name of school					
Other family members seen here:					

STATEMENT RECIPIENT					
(Please give your insurance card to the receptionist.at each visit)					
Person responsible for bill:	Birth date: / /	Address (if different):			Home phone no.: ( )
Relationship to patient					
Occupation:	Employer:	Employer address:			Employer phone no.: ( )
		INSURANCE INFORMATION			
Is this patient covered by insurance? ❑ Yes ❑ No					
Please indicate primary insurance					
Subscriber's name:	Subscriber's Policy #	Birth date: / /	Group #	Effective Date	Co-pay due at visit $
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other					
Name of secondary insurance (if applicable):	Subscriber's name:		Policy #		Group #
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other					

PLEASE COMPLETE REVERSE SIDE OF THIS FORM

IN CASE OF EMERGENCY			
Name:	Relationship to patient:	Work phone no.: ( )	Cell phone no.: ( )
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Knoxville Pediatric Associates, P.C. or insurance company to release any information required to process my claims.			
Patient Signature		*Date*	

Our Financial Policy

Your insurance is a contract between you and your insurance company and we are not a party to that contract. Therefore, financial responsibility for your treatment is yours now that you are 18 years or older. You are responsible for all copays and deductibles prior to services being rendered. If you have an insurance which we do not participate with, it is your responsibility to pay at the time of service unless payment arrangements have been made with our business office. Any account referred to a collection agency will have a service charge added. A service charge of $35 will be added for any checks drawn on insufficient funds. For your convenience we accept cash, check and Visa/Mastercard/Discover credit or debit cards.

Our Office Policy

A patient that is not seen within a 3 year span will be considered a new patient and charged accordingly.

Prescription refills will only be approved during normal business hours. It is not our policy to call in medications without the patient being seen first, unless it is a refill.

3 or more appointments missed within a 1 year span for the family are subject to dismissal from KPA. Appointments that are canceled without sufficient notice are considered a missed appointment. Missed appointments are also subject to a $35 fee per appointment.

Permission to Disclose Health Information

Please Check One

_____ **I give the physicians and/or staff of Knoxville Pediatric Associates, P.C. permission to discuss my health information with the following people.**

Name_____ Relationship_____

Name_____ Relationship_____

Please check any exclusions (do not discuss the following):

_____ Reproductive Health (STDs, pregnancy, birth control, etc.)

_____ Mental Health (includes ADD and ADHD)

_____ Other (specify)_____

_____ **I do NOT give the physicians and/or staff of Knoxville Pediatric Associates, P.C. permission to discuss my health information with anyone other than myself.**

Health Information Disclosure

I authorize Knoxville Pediatric Associates, P.C. to discuss or release information necessary to process or respond to insurance eligibility inquiries, coverage/benefit inquiries, claims inquiries, appeals, medical advice, and complaints about my health insurance coverage with KPA. I acknowledge that the information released may include individually identifiable health information about me. I understand that this consent is voluntary and that refusal to sign will not affect my ability to obtain medical treatment. I also understand that I may revoke this authorization at any time by notifying KPA in writing of an intent to revoke this authorization.

Acknowledgement of Policies

I have reviewed and accept the conditions of the financial and office policy stated above. I certify that I have provided correct information on this Patient Registration form and understand that any false statement or concealment of material may result in termination of medical care.

Missed Appointments Policy

If 3 or more appointments are missed within a 1 year span for the family are subject to dismissal from KPA. Appointments that are canceled without sufficient notice are considered a missed appointment. Missed appointments are also subject to a $35 fee per appointment.

My signature below indicates that I have read and acknowledge the above mentioned Health Information Disclosure, Financial Policy and Office Policy.

_____ _____

Patient Signature **Date**