Mat-Su Community Pediatrics Patient Registration Form

Patient Name: Date of Birth: Gender

Mailing Address: City, State: Zip Code:

Home Phone: Work Phone: Cell Phone:

Person Responsible for Billing

Please present all insurance cards at the time of service

Primary Insurance Group #:

I.D./Policy #: SSN Employer:

Policy Holder Date of Birth Relationship

Mailing Address: City, State: Zip Code:

Home Phone: Work Phone: Cell Phone:

Secondary Insurance Group #:

I.D./Policy #: SSN Employer:

Policy Holder Date of Birth Relationship

Mailing Address: City, State: Zip Code:

Home Phone: Work Phone: Cell Phone:

Pharmacy Information

Please provide us the name of your perferred pharmacy. We fax prescriptions to the pharmacy for you so they can be ready for you pick up.

Name of pharmacy:

EMERGENCY CONTACT

In the event of an emergency *who* and *how* do we make contact

Name: Relationship:

Home Phone: Work Phone: Cell Phone:

Assignment of Benefits and Financial Agreement

I hereby give lifetime authorization for payment of insurance benefits to be made directly to Mat-Su Community Pediatrics, P.C. and any assisting physicians for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default I agree to pay all costs of collection and any reasonable attorney's fees. These costs will be added to my bill. I hereby authorize this healthcare provider to release all information necessary to secure payment of benefits or to collect unpaid charges. I further agree that a photocopy of this agreement shall be as valid as the original.

Signature: _____

Date Signed

Print Name: _____

Financial Policy

Mat-Su Community Pediatrics, P.C.

Please read and understand our financial policies, your signature below indicates your aggrement and understanding of them, feel free to ask any questions

Payment options if you do not have insurance: Self Pay patients are expected to pay at the time of service. Any other financial arrangements need to be made prior to your visit. Our staff will be happy to answer any of your questions.

Payment options if you have insurance: Insurance is a contract between you and your insurance carrier. You must respond to your carrier when asked in a timely fashion to assure payment of claims. We are not a party to this contract. You agree that;

1. As a courtesy to you we will file your insurance forms to your primary and secondary insurances on your behalf.
2. We must have a copy of your insurance card, without this information your account will be treated as Self Pay.
3. If your insurance requires a referral or authorization for care we will need this prior to your appointment.
4. ALL co-pays must be made at the time of service.
5. If you receive Medicare, Medicaid or Denali Kid Care it is your responsibility to keep your file up to date.
6. Charges not paid by your insurance in 90 days become your responsibility and are payable and due.

Methods of Payment: We currently accept personal checks, and cash for services. Please be sure to bring one of these forms of payment with you at your appointment. We do not currently accept debit or credit cards this may change as the practice grows.

Statement: After your insurance responds to to your claim, if you have a balance due you will receive a statement in the mail. The statement will show any outstanding balance that you owe. The statement is due and payable when sent. If your insurance deems a service to be *"not covered"* you will be responsible for payment of the charges. We do our best to inform patients if something might not be covered, however it is your responsibility to understand the terms and limitations of your insurance.

Past due accounts: Our goal is helping you stay well while providing the finest medical care available at a fair and reasonable cost. We will help you keep your account in good standing. We can do this by making a payment plan that we both can live with. This requires that you keep in contact with us and advise us of the situation. If you do not contact us and you ignore repeated statements then after 90 days your account will be referred to an outside agency for collection. The cost of collection will be added to your account.

We shall have the right to cancel your privledge to make charges to your account at any time.
Future visits would then be on a cash or self pay basis.

Retrieval Fee: Copies of billing records are available without fee for 30 days from the date of service. Requests beyond these limits require a research fee which is currently $20.00. This fee is not covered by insurance and is payable upon pick up.

Divorce: We are not a party to your divorce. We are concerned with the health and welfare of your children. The responsibility for payment for services rendered rests with the parent seeking treatment. Any other arrangement is the responsibility of the adult persons involved. We will be happy to bill the other parents insurance if we have that information.

Signature: _____

Print Name: _____ Date Signed: _____

Digital Signature Field: _____

1. AUTHORIZATION FOR THE CARE OF A MINOR

To whom it may concern;

I give permission for Mat-SU Community Pediatrics,P.C. and its physicians and assistants to provide any necessary medical care to my minor child.

My child's full name:

Date of Birth:

This authorization expires on my child's 18th birthday, unless revoked.

In the case of my absence, the following person or persons may seek treatment for my child should health care be required.

Name: Relationship:

Name: Relationship:

Name: Relationship:

2. CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Mat-Su Community Pediatrics, P.C. to use and disclose protected health information about me and they may : *[check all that apply]*

☐ call my home ☐ mail to my home ☐ e-Mail me E-mail Address:

Mat-Su Community Pediatrics, P.C. leave a voice mail or message in reference to:

☐ appointment reminders ☐ insurance items ☐ calls pertaining to clinical care

3. Written Acknowledgement Form

I have read and understand the previous forms and thier content. I have had an opportunity to ask questions. I have read and received or been directed to an electronic source to read Mat-Su Community Pediatrics Privacy policies.

Signature: _____

Print Name: _____ Date Signed:

Digital Signature Field:

Mat-Su Community Pediatrics
3750 E. Country Field Circle Ste C
Wasilla, Alaska 99654
Phone: (907) 357-2955 Medical Record Fax: (907) 357-9348
HIPPA compliant release of information

Patients Name: | Date of Birth:

Address:

City, State, Zip

Phone Number | Phone Number

I REQUEST MEDICAL INFORMATION FROM:

Physician/Hospitai:

Address:

City, State, Zip:

Phone Number | Phone Number

I AUTHORIZE THIS INFORMATION TO BE DISCLOSED TO:

Physician/Hospitai:

Address:

City, State, Zip

Phone Number: | Phone Number:

I authorize the following information be released from my record(s):

☐ Discharge Summary ☐ History & Physical ☐ Consultation ☐ Operative Report

☐ ER Record ☐ Laboratory Reports ☒ Entire Medical Record Other:

This information is disclosed to youfrom records protected by federal confidentiality laws. Federal law prohibits you from making further disclosure of this information unless such is expressly permitted by the written consent of the person to whom it pertains. This authorization expires 180 days from signing.

Signature: Date Signed:

Print Name: Relationship: 0

Digital Signature Field:

When form is complete click here to Print Form