Acct. # ____________________

FAMILY REGISTRATION

CHILDREN				
Name		DOB	M	F
Name		DOB	M	F
Name		DOB	M	F
Name		DOB	M	F
Does child(ren) live with both parents? Y/N		If not, who is the legal guardian?		
Emergency contact name		Phone	Relationship	

FATHER				
Last Name	First	MI	DOB	SS#
Street Address		City	State	Zip Code
Primary Phone # *(Cell, Home, Office)*	Alternate Phone # *(Cell, Home, Office)*		Marital Status: S M D W	
Email	Employer		Occupation	

MOTHER				
Last Name	First	Maiden	DOB	SS#
Street Address		City	State	Zip Code
Primary Phone # *(Cell, Home, Office)*	Alternate Phone # *(Cell, Home, Office)*		Marital Status: S M D W	
Email	Employer		Occupation	

CANCELLATION POLICY

Our requested cancellation policy is a 24 hour notice for well child check up visits and consultations (48 hour notice for a double well child check up visit). A $50.00 fee will be assessed per child for any missed or cancelled appointments without appropriate notice. Your cancellation must be made during regular office hours. As always, emergencies and unforeseen circumstances are taken into consideration.

Signature: ______________________________ **Date:** ______________________________

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

Please sign below that you have been offered an opportunity to review a copy of our HIPAA notice. You are entitled to a personal copy of the notice at any time to keep for your records.

Patient Name: *(please print)* ______________________________ **Relationship to patient:** ______________________

Signature of Parent/Guardian: ______________________________ **Date:** ______________________________

FINANCIAL STATEMENT

I understand that in order for PAMPA to file my insurance, I must present a valid card at the time of each visit. If you do not have proof of insurance, you must pay for services rendered at the time of service.

I authorize my children to receive health services with the understanding that if our insurance or managed care company determines that any services provided are non-covered services, I will be billed and held responsible for services rendered. Co-pays, deductibles and co-insurance amounts are due at time of service. A billing fee of $15 a month will be applied to any balance not paid at time of service.
Administrative Fee (ASF) is a yearly fee intended to cover the cost of certain administrative services we may provide which are not covered by your insurance. We collect this fee on an annual basis.

I authorize payment of medical benefits to P.A.M.P.A for medical services rendered to the patient(s) named above.

Insured or authorized person's signature: ____

Print Name: ______________________________ **Date:** ______________________________