

PEDIATRIC REGISTRATION (under age 18)

Today's Date: _____

PLEASE DO NOT ABBREVIATE ANY INFORMATION

Patient Information DOB _____ SEX: M F

First Name: _____ MI: ___ Last Name: _____ Marital Status: CHILD

Address: _____ SSN: _____

City: _____ State: _____ ZIP: _____

Home Phone: _____ Cell Phone: _____

Primary Care Physician: _____

MOTHER DOB _____ SEX: F

First Name: _____ MI: ___ Last Name: _____ Marital Status: MAR'D SING DIV OTH

Address: _____ SSN: _____

City: _____ State: _____ ZIP: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Employer Name (no abbreviations please): _____

FATHER DOB _____ SEX: M

First Name: _____ MI: ___ Last Name: _____ Marital Status: MAR'D SING DIV OTH

Address: _____ SSN: _____

City: _____ State: _____ ZIP: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Employer Name (no abbreviations please): _____

OTHER Relationship to Patient: _____ DOB _____ SEX: M F

First Name: _____ MI: ___ Last Name: _____ Marital Status: MAR'D SING DIV OTH

Address: _____ SSN: _____

City: _____ State: _____ ZIP: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Employer Name (no abbreviations please): _____

Insurance Information Who carries this insurance (circle one)? MOTHER FATHER OTHER

Insurance Name: _____

Ins ID# (Policy #) _____ Group # _____

IS YOUR CHILD COVERED BY MEDICAID? YES NO IF YES, YOUR CHILD'S MEDICAID #: _____

IS YOUR CHILD COVERED BY CHP+? YES NO IF YES, YOUR CHILD'S CHP+ # _____

Referring Physician Information

Complete Name of Physician Who Referred You to Us: _____

Phone Number of Referring Physician: _____

Emergency Contact

Name: _____

Phone: _____ Relationship to Patient: _____

UPDATES: I verify that the information on this form is current and unchanged.

DATE/INITIALS:

Guarantor's Billing Agreement

- 1) I understand that if the insurance claim is denied due to incorrect information that I have provided, I will be billed and payment in full will be due immediately.
- 2) I hereby request and authorize Mountain View Medical Group physicians & personnel to deliver medical care to me.
- 3) If Mountain View Medical Group is contracted with my insurance company, I authorize assignment of payment directly to the doctor for services provided me. I understand that Mountain View Medical Group will file the claim with my insurance company and that I am responsible for following up with my insurance company to insure my claim is paid within 60 days of the date of service.
- 4) I understand that, under the terms of the contract of the insurance company, co-payments must be paid at every visit.
- 5) If I have insurance that Mountain View Medical Group is not contracted with, I agree to pay the bill in full at the time services are provided. I understand that Mountain View Medical Group will file a claim with my primary insurance company (except Tricare) as a courtesy, but that it is my responsibility to follow up with my insurance company to insure personal reimbursement by them.
- 6) I understand that if I have no insurance coverage, I agree to pay the balance in full at the time services are provided.
- 7) I understand that medical records are the property of the physicians of Mountain View Medical Group; however, I am entitled to copies, with sufficient advanced notice, upon my written request. I understand that there may be a charge for these copies.
- 8) I hereby authorize the release of my medical information to the insurance company concerning any illness and treatment.
- 9) I acknowledge that I can obtain a copy of the Mountain View Medical Group's Privacy Rights / HIPAA Information from the front desk upon my request.
- 10) I understand that a \$35.00 fee may be charged for all appointments missed or not canceled at least 24-hours in advance.
- 11) I understand that if my account becomes past due, Mountain View Medical Group will take the necessary steps to collect this debt, which will also include all associated collection fees, attorney/legal fees, and court costs.
- 12) I understand that I am responsible for knowing the benefits of the specific insurance plan(s) I have purchased, and that MVMG is not responsible for interpreting these benefits, or for how my insurance company(ies) process the claims. I further understand that MVMG cannot serve as an intermediary between my insurance company and myself in claims processing or claims disputes; that I must personally resolve these matters with my insurance company.

Guarantor Signature _____ Date _____

Communication Consent:

A. I DO CONSENT TO LEAVE DETAILED MESSAGES AND/OR DISCUSSION:

I give Mountain View Medical Group, P.C., and their staff permission to leave detailed phone messages on, or to discuss my child's medical care and/or my billing account with, the following: (please initial each one you consent to). This consent will remain in effect until rescinded in writing.

My home phone voice mail # _____	Medical Care _____	Billing Account _____
My cell phone voice mail # _____	Medical Care _____	Billing Account _____
My work phone voice mail # _____	Medical Care _____	Billing Account _____
My spouse (name) _____	Medical Care _____	Billing Account _____
Other (name) _____ phone # _____	Medical Care _____	Billing Account _____

Signature: _____ Date: _____

B. I DO NOT CONSENT TO LEAVE DETAILED MESSAGES:

I wish to be contacted personally, and I do not authorize MVMG to leave detailed messages or conduct discussions regarding my child's medical care and/or billing account with anyone other than myself.

Signature: _____ Date: _____

C. REVOCATION OF PRIOR CONSENT:

I wish to rescind the above authorizations.

Signature: _____ Date: _____