Patient Registration

Tell us about the patient: **(Please Make Sure to Complete BOTH Sides of This Form)**

Last Name:_____First Name:_____MI:_____

Nickname:_____Age:_____Date of Birth:_____

Address:_____

City:_____State:_____Zip:_____

Gender: ○Male ○Female

Tell us about the family:

Parent 1: Last Name:_____First Name:_____MI:_____

Address (if different from patient):_____**DOB**:_____

City:_____State:_____Zip:_____

Phone (Home):_____(Cell):_____(Work):_____

Occupation:_____Employer:_____

Email:_____

Parent 2: Last Name:_____First Name:_____MI:_____

Address (if different from patient):_____**DOB**:_____

City:_____State:_____Zip:_____

Phone (Home):_____(Cell):_____(Work):_____

Occupation:_____Employer:_____

Email:_____

Siblings:

Name_____Date of Birth:_____

Name_____Date of Birth:_____

Name_____Date of Birth:_____

Who should we call in case of emergency?

Last Name:_____First Name:_____Best Phone Number:_____

Relationship to Patient:_____

Will insurance be used for today's visit?

- ○ No. The visit will be paid for today.
- ○ Yes. Please provide the receptionist with your insurance card. If you are covered by multiple insurance companies, indicate which is primary, secondary, etc.

Policy Holder:_____**DOB:**_____

Acorn Pediatrics accepts most major insurance plans. Check with the receptionist for more information.

Privacy Policy **(Please mark all that apply)**

- ○ I acknowledge that I have received the Acorn Pediatrics Notice of Privacy Policy.
- ○ I authorize Acorn Pediatrics to contact me regarding my child's appointment, health information, lab results, billing problems or any other situation relating to my child's healthcare.
  I prefer to be contacted at the following phone number: ○Home ○Cell ○Work
- ○ I authorize Acorn Pediatrics to leave a detailed message regarding my child's healthcare. Mark all that apply:

  ○Voicemail ○With the following individual(s):_____Phone:_____

- ○ I authorize Acorn Pediatrics to send appointment confirmation reminders to my email or to my phone via text message:

  Email:_____Text SMS Phone Number:_____

Authorization to Treat in Absence of Parent or Guardian (optional)

○ I authorize my child to be brought to Acorn Pediatrics by _____. I consent for my child to be treated, and I agree to be responsible for the cost of such care.

Agreement to Pay

○ I authorize the release of my child's medical records to my health plan, insurance company, or Medicaid, as applicable, for payment. **I request that my health plan, insurance company, or Medicaid, as applicable, make payment for services I receive at Acorn Pediatrics directly to Acorn Pediatrics, LLC.** I understand that I am responsible for payment for any services that are not covered by any health plan, insurance company, or Medicaid, including co-payments and deductibles. I understand **co-payments are due prior to my child being seen**. I understand that if my child does not have health insurance, or if I do not mark this circle, I will be responsible for payment which is due at the end of each visit. For any balance that remains unpaid 60 days after the date of service, I agree to pay 1.5% monthly interest charges (18% APR). Should any balance be referred to a collection agency, I agree to pay an additional fee.

By signing below, I am confirming that I understand and consent to the assignment of benefits, payment responsibility, treatment(s), and disclosures above.

Patient Name:_____Date:_____

Signature:_____

Relationship to patient: ○Parent ○Guardian ○Other:_____

THANK YOU FOR CHOOSING ACORN PEDIATRICS! How did you hear about us:_____