



MR#: _____

Date: _____

PEDIATRIC PATIENT REGISTRATION

PLEASE PRINT

- PATIENT INFORMATION -

PATIENT'S NAME: _____ DATE OF BIRTH: _____ AGE: _____

SOCIAL SECURITY #: _____ MALE FEMALE HOME PHONE: _____

ADDRESS: _____ CITY/STATE/ZIP: _____

Patient's Race: White or Caucasian Black or African American Asian American Indian Native Hawaiian
 All Other Patient Refused Unknown

Ethnicity: Hispanic Non-Hispanic Patient Refused Unknown

Language: English Spanish Other _____ Interpretation Needed

- PARENT/GUARDIAN* INFORMATION -

**Legal Guardian must provide documentation of guardianship status.*

RESPONSIBLE FOR BILL AFTER INSURANCE PAYS

MOTHER'S NAME: _____

SOC SEC #: _____ DATE OF BIRTH: _____

(Is the patient's/guardian's address the same as the Patient's address above? Yes No If Yes, do not complete the address information)

ADDRESS: _____

CITY/STATE/ZIP: _____

HOME PHONE: _____ CELL PHONE: _____

PLACE OF EMPLOYMENT: _____ Full Time Part Time

WORK PHONE: _____

EMAIL: _____

RESPONSIBLE FOR BILL AFTER INSURANCE PAYS

FATHER'S NAME: _____

SOC SEC #: _____ DATE OF BIRTH: _____

(Is the patient's/guardian's address the same as the Patient's address above? Yes No If Yes, do not complete the address information)

ADDRESS: _____

CITY/STATE/ZIP: _____

HOME PHONE: _____ CELL PHONE: _____

PLACE OF EMPLOYMENT: _____ Full Time Part Time

WORK PHONE: _____

EMAIL: _____

- EMERGENCY INFORMATION - (PERSON NOT LIVING AT THE SAME ADDRESS; MUST HAVE PHONE)

NAME _____ RELATIONSHIP TO PATIENT _____

HOME PHONE _____ CELL PHONE _____ WORK PHONE _____



- ASSIGNMENT OF BENEFITS & PAYMENT -

ASSIGNMENT OF BENEFITS - I assign to Hattiesburg Clinic all insurance benefits and settlements, whether medical or liability insurance, for the full amount of the total medical care charges. I also assign the proceeds of any judgment or settlement of any claim with any third party, or other amounts determined to payable in connection with treatment provided at Hattiesburg Clinic. I authorize payment of all benefits and settlements to be paid directly to Hattiesburg Clinic for services rendered. This authorization is effective indefinitely unless patient or the patient's representative revokes this arrangement.

MEDICAL RECORD & RELEASE OF INFORMATION - I authorize the release of all medical information necessary to process medical claims and permit the following to be used in place of this original document: (1) a photocopy of other facsimile reproduction of this authorization, or (2) use of a computer to indicate that my signature is on file at Hattiesburg Clinic. By signing this document, I also acknowledge that I have received a copy of the organization's Notice of Privacy Practices. This acknowledgement is required by the Health Insurance Portability and Accountability Act (HIPAA) to ensure that I have been made aware of my privacy rights.

PAYMENT POLICIES - As a courtesy to its patients, Hattiesburg Clinic assists in the submission of medical insurance claims to insurance companies for payment. I understand that it is my responsibility to confirm that Hattiesburg Clinic is a participant under my policy. Further, I understand that my insurance company may not cover fully (or at all) cover my bills for services provided, and that I will be responsible for the payment of any remaining balance due. I understand that all co-payments and deductibles are payable at the time of service.

I understand that it is my responsibility to provide Hattiesburg Clinic with appropriate and current insurance information – and to notify Hattiesburg Clinic immediately upon any change in my insurance coverage – to ensure efficient claims billing and payment. In the event that I fail to provide all necessary and current insurance information, I understand that my insurance company(ies) may deny payment of claims related to services rendered to me, and I understand that I may be fully responsible for my entire account balance.

I understand that a single account will be created for patients in my same family, such as husband, wife and children. Hattiesburg Clinic prepares statements on patient accounts on a monthly cycle. I understand that all charges to my account with the Clinic are due and payable within the month following the date of the statement on which the charges first appear. I understand that I will be responsible for paying, on behalf of myself, my spouse, and/or my children, co-payments, deductibles, and any fees relating to services rendered that are not fully (or at all) covered by my insurance company(ies). I understand that an 8% per month interest fee may be added to my balances which are over 90 days past due.

In the event of failure to pay for medical services rendered to me, my spouse and/or my children, I understand that I may be referred to a collections agency for non-payment of fees due for services rendered by Hattiesburg Clinic. I understand that I will be responsible for all attorney fees plus all costs associated with the collection process, such as court costs and any fees assessed by the collections agency, and that these fees and costs will be added to my account balance. I understand that I will be responsible for paying the entire amount of my balance due in addition to the collection agency fee. Further, I understand that my medical information will necessarily be revealed in these efforts to collect payment of monies owed.

PRINTED NAME

SIGNATURE

DATE