BRIGHTON HILL PEDIATRICS REGISTRATION FORM

PLEASE FILL OUT FRONT & BACK 9/2018

Date: _____Child's Dr. /N.P. _____

Patient/Child's First & Last Name(s)	**DOB**	**Gender M/F**	**Lives with Mother/Father/Both**
_____	_____	_____	_____

PLEASE CIRCLE OR FILL IN THE REQUIRED INFORMATION FOR COMPLIANCE WITH STATE AND FEDERAL REGULATIONS

1. Ethnicity: Hispanic Latino Neither **2. Language: _____**

3. Race: Native American Asian Black/African American Native Hawaiian White

Mother's Maiden Name _____New York State Law **REQUIRES** this information for the Immunization Registry.

FAMILY INFORMATION

Parent/Guardian: Name _____DOB_____SEX: M F SS#_____

Address _____City_____State_____Zip _____

Home Phone # _____Cell Phone # _____ Work #_____

Employer _____Occupation _____

I give BHP permission to call or leave messages on (circle all that apply): Home Cell Work

Parent/Guardian: Name_____ DOB _____SEX: M F SS#_____

Address _____City_____State_____Zip_____

Home Phone #_____Cell Phone # _____ Work #_____

Employer _____Occupation _____

I give BHP permission to call or leave messages on (circle all that apply): Home Cell Work

E-MAIL Address_____ Receive E-Mail Newsletter Y_____ N_____

Pharmacy of Choice_____

EMERGENCY CONTACTS (other than a parent or guardian) **Name(s), Phone Number(s) and Relationship**_____

_____

PATIENT CONSENT TO TREAT AND CONSENT TO USE AND DISCLOSE HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS

I consent to the examination and treatment of my children by the physicians and nursing staff of Brighton Hill Pediatrics, R.L.L.P. I understand that as part of my health care, Brighton Hill Pediatrics, R.L.L.P., originates and maintains paper and/or electronic records describing me and for my children's health history, including, but not limited to, office visits and treatment rendered, clinical laboratory reports, diagnostic test results, x-ray reports, hospital reports, mental health records, HIV reports and confidential chart material. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill,
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this Consent,
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Brighton Hill Pediatrics, R.L.L.P. is not required to agree to the restrictions requested. Should Brighton Hill Pediatrics, R.L.L.P. not agree to my requested restrictions, the practice will so inform me in writing. I understand that I may revoke this Consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this Consent or revoking this Consent, Brighton Hill Pediatrics, R.L.L.P., may refuse to treat me. I further understand that Brighton Hill Pediatrics, R.L.L.P. reserves the right to change their notice and practices in accordance with Section 164.520 of the Code of Federal Regulations. Should Brighton Hill Pediatrics, R.L.L.P. change their notice, it will be provided to me, if I so request it. I wish to have the following restrictions to the use or disclosure of my health information:

_____

_____

I understand that as part of Brighton Hill Pediatrics, R.L.L.P.'s treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted-uses, including disclosures via fax. I fully understand the terms of this Consent. Signed_____Date_____

BILLING INFORMATION (PLEASE COMPLETE THIS ENTIRE SECTION, INCLUDING POLICY ID'S)

RESPONSIBLE PARTY FOR BILLS (name/address):_____

Primary Insurance Company _____**Policy/ID #**_____

Subscriber's First & Last Name _____DOB_____

Secondary Insurance Company _____**Policy/ID #** _____

Subscriber's First & Last Name _____DOB_____

BRIGHTON HILL PEDIATRICS FINANCIAL POLICY

- **YOU ARE RESPONSIBLE TO KNOW THE TERMS AND CONDITIONS OF YOUR INSURANCE PLAN.**
- You must provide our office with ALL insurance information and changes in a timely fashion or we will be unable to bill your insurance company for you and you will be responsible for the entire balance. You must bring your insurance card to every appointment.
- You are responsible to update the coordination of benefit information for one or more insurance companies on an annual basis; balances due to your failure to update COB information are your responsibility.
- It is important that you list one of our doctors as your child/children's primary care physician or claims will be denied and you will be responsible for payment in full.
- Copays are due at the time of service. The parent or legal guardian bringing in the child is responsible for appropriate copays at the time of visit or for the balance due determined by the insurance explanation of benefits.
- If you do not have insurance or have insurance that our office does not participate with, full payment is expected at the time of service.
- Account balances not paid in full within 60 days will be subject to our collection process. You may be asked to secure another primary physician for your children.
- There is a $20 fee for all returned checks.
- There may be a fee charged for record requests, transfers, or forms.
- There is an additional fee charged if your child is seen in our office after hours, on Saturdays, Sundays, or holidays. You may be responsible for payment of this additional fee if it is not paid by your insurance company.
- If you declare bankruptcy, you may need to secure another primary physician for your children, as we may no longer be responsible for their medical care. Ask to review our Discharge for Bankruptcy policy.

I have read and agree to the terms of Brighton Hill Pediatrics financial policy. I understand that I am responsible to know the terms and conditions of my insurance plan. I agree to pay for any and all charges deemed my responsibility by my insurance company. I have been offered a copy of this policy for my records. I give permission to call or leave messages on numbers provided on demographic form, including cell phone numbers.

Signed_____ Date_____