children's
MEDICAL ASSOCIATION, P.A.

OSCAR BETANCOURT, M.D.
LAURENCE D. PEARSON, M.D.
LISA J. SIROTA, M.D.
MARK STAVITSKY, M.D.
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BRENDA A. AUSTIN, ARNP
ROBBIE ZBAR, ARNP
MICHELE ROTH, ARNP
MARTHA HOLLEY, ARNP
FELLOWS AMERICAN ACADEMY OF PEDIATRICS

2011

PATIENT REGISTRATION FORM

*Form **MUST** be completed **ENTIRELY!***

Today's Date: ____/____/____ Office Location: ☐Plantation ☐Tamarac ☐Heron Bay
FECHA DE HOY UBICACION DE OFICINA

Patient's First Name: _____ Patient's Last Name: _____
PRIMER NOMBRE DE PACIENTE APPELLEDO DE PACIENTE

DOB: ____/____/____ SEX: Male / Female (circle one) SS#: _____
FECHA DE NACIMIENTO SEXO: MASCULINO / FEMENINO NUMERO DE SEGURO SOCIAL

Permanent Address: _____
DIRECCION

_____

Home Phone: _____ Alternate Phone: _____
NUMERO DE TELEFONO (casa) NUMERO ALTERNATIVO

Parent/Guardian Information

Mother's Name: _____ DOB: ____/____/____ SS#: _____
NOMBRE DE MADRE FECHA DE NACIMIENTO NUMERO DE SEGURO SOCIAL

Father's Name: _____ DOB: ____/____/____ SS#: _____
NOMBRE DE PADRE FECHA DE NACIMIENTO NUMERO DE SEGURO SOCIAL

Emergency Contact/Relation: _____ Phone: _____
EN CASO DE EMERGENCIA/RELACION NUMERO DE TELEFONO

Insurance Information

Insurance Company: _____ Phone: _____
COMPANIA DE SEGURO MEDICO NUMERO DE TELEFONO (SEGURO)

Claims Mailing Address: _____
DIRECCION DE ENVIO

_____

Insured Party: _____ DOB: ____/____/____ SS# _____
ASEGURADO FECHA DE NACIMIENTO NUMERO DE SEGURO SOCIAL

Subscriber/Policy/Member#: _____ Group #: _____
NUMERO DE ID/POLIZA/MIEMBRO NUMERO DE GRUPO

Signature: _____ Print Name: _____ Date: ____/____/____
FIRMA NOMBRE IMPRENTA FECHA DE HOY

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EMERGENCY CARE AUTHORIZATION

By my signature below, I authorize the above mentioned doctors to perform any necessary emergency care for my child; if I am unable to be located at the time of need for such emergency medical care.

Parent/Guardian Signature: _____ Date: ___/___/____

I hereby authorize my insurance benefits to be paid directly to the above physician, realizing I am responsible to pay non-covered services and I hereby authorize the release of pertinent medical information to insurance carriers.

FINANCIAL POLICY

If you have Medicaid, we will verify coverage on the date of service. If you are not approved with coverage by Medicaid, charges from a well visit on that date of service will be payable at the time of service, or will be encouraged to reschedule their well visit on a later date. Patients being seen for a sick visit will be offered the opportunity to sign a waiver promising to pay for charges incurred on that date of service. Patients experiencing financial hardship will be considered on a one to one basis. Approval of a payment arrangement must be obtained from our administrator.

Newborns that are in process of being added to a commercial insurance policy must furnish proof on letterhead from the guarantor's employer that they have been notified of the newborn's birth. If this proof has not been received by the first visit, the newborn's parent(s) will be asked to contact their employer. The parent can request it to be faxed to our billing office. The billing office will file this document in the newborn's chart. Newborn's that are to be covered by Medicaid will be verified of coverage on the date of service. The parent/guardian will be asked to call Medicaid and enroll at the time of the first office visit if this has not already been done. The patient will be allowed to sign a waiver on the newborn's first visit to our office. All future newborn appointments will be at the discretion of the doctor treating the newborn, if there is a delay in the Medicaid coverage. Subsequent visits may require payment.

We assume and act on the assumption that you intend to pay your bill in full and on time. The patient, insured, and/or legal guardian are ultimately responsible for payment of fees for medical treatment.

We will never refuse to provide treatment for urgent or life threatening medical conditions based on a patients ability to pay. Your child's health is our immediate concern. If you are truly indignant and unable to pay for urgent related medical expenses, ask to speak with our administrator.

We accept cash, MasterCard, and Visa credit cards.

I have read the above Financial Policy:

Signature: _____ Print Name: _____ Date: ___/___/____