Patient Number (Office Use Only) _____

Pediatric Partners of Jeffersontown

Patient Registration

*Child Last Name:*_____*First Name:*_____*MI*____

*DOB:*____/____/_____ *Sex:* M/F Primary Language: _____

Ethnicity: Hispanic/ Non-Hispanic/ Unknown/ Decline to Answer

Race: Asian/ Black/ White/ Hawaiian/ Decline to Answer

Address: _____

City: _____ State: _____ Zip Code: _____

Mother Name: _____ DOB: _____

Phone Number: _____ Alternate Phone Number: _____

Employer: _____ Work Phone: _____

Email: _____ SSN: _____

☐ Genetic Mother ☐ Stepmother ☐ Legal Guardian

Address: ☐ Check if same as above

_____

City: _____ State: _____ Zip Code: _____

Father Name: _____ DOB: _____

Phone Number: _____ Alternate Phone Number: _____

Employer: _____ Work Phone: _____

Email: _____ SSN: _____

☐ Genetic Father ☐ Stepfather ☐ Legal Guardian

Address: ☐ Check if same as above

_____

City: _____ State: _____ Zip Code: _____

If parents are divorced or separated, who has custody? _____

Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? YES/NO

If yes, please explain and provide a copy of any legal paperwork that supports this restriction.

Patient Number (Office Use Only) _____

ALTERNATIVE GUARDIANS

In case of emergency, please contact:

Name: _____ Relationship: _____ Phone: _____

The following people have my permission, as legal guardian, to bring my child in for treatment in the event that I am not able to be present:

1. _____ Relationship:_____ Phone: _____
2. _____ Relationship:_____ Phone: _____
3. _____ Relationship:_____ Phone: _____
4. _____ Relationship:_____ Phone: _____

Parent/ Guardian Signature:_____ Date:_____

Insurance

Primary Policy

Insurance Policy Name: _____

Policy Holder Name: _____

Who should receive billing statements? _____

Does patient have other insurance? Y/N If yes, please fill out below:

Secondary Policy

Insurance Policy Name: _____

Policy Holder Name: _____

Who should receive billing statements? _____

Patient Number (Office Use Only) _____

Insurance Assignment of Benefits

We will file your insurance if you are covered under a plan in which the office participates. We expect co-payments at the time of service. We cannot bill for co-payments. If you do not have insurance and need to set up a payment arrangement for your account we will be happy to work with you.

I hereby assign benefits which may be due and payable from my insurance company to Pediatric Partners of Jeffersontown. I also authorize Pediatric Partners of Jeffersontown to release any necessary information on my behalf to the insurance carrier, including private and medical record information, as necessary for payment of claims filed for services rendered by Pediatric Partners of Jeffersontown, or as requested by your insurance company.

Parent/ Guardian: _____ Date:_____

Non-Covered Services

I understand that my insurance company may not pay for some services that my child's doctors determine are medically necessary. I hereby agree that I am financially responsible for these services.

Parent/ Guardian: _____ Date:_____

Consent for Treatment

This is to certify that I, the parent or legal guardian of _____, request treatment of my child by the physicians and/ or staff of Pediatric Partners of Jeffersontown, PLLC. Authorization is hereby granted for such treatment.

Parent/ Guardian: _____ Date:_____

Missed Appointment Policy

After one missed appointment, a warning letter will be issued. At the second missed appointment, a $25.00 fee will be assessed. At the third missed appointment, we may dismiss your family from the practice.

Parent/ Guardian: _____ Date:_____

Patient Number (Office Use Only) _____

Pediatric Partners of Jeffersontown, PLLC

Joseph Pappalardo, MD, FAAP

Mari Knights, MD, FAAP

Debbie Wallace, MD, FAAP

Sally Diebold, MD, FAAP

3840 Ruckriegel Parkway, Suite 105 Phone (502) 261-7227

Louisville, Kentucky 40299 Fax (502) 261-7157

Patient Consent: For use and disclosure of protected health information

- I hereby acknowledge that I have received and had an opportunity to ask questions regarding the Notice of Privacy Practices for Pediatric Partners of Jeffersontown.

- I consent that Pediatric Partners of Jeffersontown may use and disclose protected health information about myself and/or my child to carry out treatment, payment and health operations (TPO).

- I consent that, Pediatric Partners of Jeffersontown may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and clinical care- including lab results. In addition, I permit communications related to TPO to be mailed to my home or other designated location.

- I further consent, that with my verbal request and permission, Pediatric Partners of Jeffersontown may provide routine written or faxed copies of immunizations, camps and athletic leagues.

Patient Name: _____

Signature of Patient or Patient's Guardian: Date Signed:

_____ _____