

WILLOWS PEDIATRIC GROUP P.C. FAMILY REGISTRATION FORM

(please print)

Insurance Holder's Name: _____ **Date:** _____

Billing Address: _____ **Telephone:** _____

_____ **Emergency Contact:** _____

Other Address: _____ **Emergency Contact#:** _____

Email: _____ **Referred By:** _____

Insurance Information: (effective date of policy = _____)

Primary Insurance Company: _____ **Employer:** _____

Policy #: _____ **Group #:** _____

(you must provide us with a copy of your current insurance card)

Family Information:

Parent's Name: _____ **Parent's Name:** _____

SS#: _____ **DOB:** _____ **SS#:** _____ **DOB:** _____

Cell Phone: _____ **Cell Phone:** _____

Employer: _____ **Employer:** _____

Work #: _____ **Work #:** _____

Child: _____ **DOB:** _____ **SS#:** _____

Child: _____ **DOB:** _____ **SS#:** _____

Child: _____ **DOB:** _____ **SS#:** _____

Child: _____ **DOB:** _____ **SS#:** _____

Child: _____ **DOB:** _____ **SS#:** _____

Child: _____ **DOB:** _____ **SS#:** _____

Authorization of Treatment and Assignment of Benefits:

I authorize Willows Pediatric Group P.C. to treat my child/children. I further authorize the release of medical information necessary for the completion of insurance forms. I authorize payment directly to Willows Pediatric Group P.C. for any and all medical or surgical benefits otherwise payable to me under the terms of my insurance. I also affirm that I will reimburse Willows Pediatric Group P.C. for any payments my insurance company may have sent to me in error. I understand that I am financially responsible for all co-payments and any charges not covered under my insurance benefits. I also understand that I am responsible for advising Willows Pediatric Group P.C. of any and all changes to my insurance coverage. Payment of co-pays are due on date of service. Failure to pay co-pay at that time will result in an additional administrative fee. Our office requires 24 hours notice for future appointment cancellations, or 4 hours notice for appointments made within 24 hours of the appointment time. Failure to provide this notice will incur a cancellation fee.

Signature: _____ **Relationship:** _____ **Date:** _____