**WILLOWS PEDIATRIC GROUP FAMILY REGISTRATION FORM**

**BILLING INFORMATION**:

Name of Person Responsible for Bills: _____ Date:_____

Billing Address: _____ Preferred Phone # Contact: _____

(City, State, Zip): _____ Emergency Contact Name: _____

Email: _____ Emergency Contact #: _____

**INSURANCE INFORMATION**: *(CURRENT INSURANCE CARD MUST BE SHOWN AT EVERY VISIT)*

Insurance Holder's Name: _____

Primary Insurance Company: _____ Policy Effective Date: _____

Policy #/Member ID#: _____ Group #: _____

**FAMILY INFORMATION:**

**Parent/Guardian**: _____ **Parent/Guardian**: _____

DOB: _____ DOB: _____

Cell Phone: _____ Cell Phone: _____

Work #: _____ Work #: _____

Employer: _____ Employer: _____

Child's Name: _____ DOB: _____ Cell Phone: _____

Child's Name: _____ DOB: _____ Cell Phone: _____

Child's Name: _____ DOB: _____ Cell Phone: _____

Child's Name: _____ DOB: _____ Cell Phone: _____

Child's Name: _____ DOB: _____ Cell Phone: _____

As a service we attempt (but do NOT guarantee) to confirm all appointments 48hrs prior to appointment with a text and 24 hours prior to appointment with a call. Please indicate which numbers you would like us to use.

text # _____ telephone # _____

**AUTHORIZATION OF TREATMENT AND ASSIGNMENT OF BENEFITS:** *(Please initial)*

_____ I authorize Willow Pediatric Group to treat my child/children.

_____ I authorize the release of medical information necessary for the completion of insurance forms.

_____ I authorize payment directly to Willows Pediatric Group for any and all medical or surgical benefits otherwise payable to me under the terms of my insurance, and will reimburse Willows for any payments my insurance company may have sent me in error.

**PAYMENT POLICIES:** *(Please initial)*

_____ You are responsible to present a copy of your insurance card at each visit so that we can scan it into our system. If one is not presented, then you will be asked to sign a form certifying that there has been no change in your insurance coverage since the last card presented.

_____ If you have new insurance but do not present a card to us at time of service, we will hold your claim for 10 days, allowing you to get a copy of the new insurance card to us. If a new card is not presented then, the total charges will become your responsibility and billed to you.

_____ 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.

_____ Private Pay patients will be expected to pay at the time of the visit for all services rendered. If you have a financial hardship, please talk with our business manager

_____ I understand that I am financially responsible for all co-payments, deductible, co-insurance and any charges not covered under my insurance benefits.

_____ I may decline any service before it is rendered.

_____ Every insurance company has a different policy regarding what services it will cover and how they "classify" each visit. Once a service is rendered, if your insurance company classifies it as a non-covered service or puts the charges to your deductible you will be responsible for payment of these services.

_____ If your child or adolescent arrives alone or with another adult all payment policies remain the same, once the service is rendered you will be responsible as above for payment.

_____ Our office requires 24-hour notice for future appointment cancellation and rescheduling, or 4-hour notice for appointments made within 24 hours of the appointment time. Failure to provide this notice will incur a cancellation fee.

_____ Evening, and Weekend Visits will be reported with a separate additional code to your insurance company. These after-hours codes may or may not be paid by your insurance company. You will be responsible for any non-covered charges per your insurance policy.

_____ The American Academy of Pediatrics and Willows believes in yearly well care. Please know your insurance policy. Unfortunately, all insurance companies do not necessarily agree. We suggest that you consult your insurance company to determine the frequency of well care visits and what components they will cover. Once the services are rendered you will be responsible for the charges.

_____ Forms: We will give all our patients one Connecticut Health Assessment School Form at the time of your well care visit. Any additional forms requested will incur a fee, and forms required emergently (within 24 hours) will also incur an additional fee.

_____ Divorce/Split Family Situations: The parent bringing the child in for care is responsible for the co-payments. Both parents are responsible for payment on unpaid balances. If payment issues exist, they must be resolved between the parents.

**ACKNOWLEDGEMENT OF AUTHORIZATION, ASSIGNMENT OF BENEFITS AND PAYMENT POLICIES:**

Signature: _____ Date: _____

Print Name: _____ Relationship: _____