wasatch pediatrics

PATIENT REGISTRATION

Preferred Doctor:_____ Preferred Pharmacy Name/City:_____

PATIENT INFORMATION

Last Name:_____ First Name:_____ Middle:_____

Preferred Patient Name:_____ Date of Birth:_____ Sex: ☐ Male ☐ Female

Race:_____ Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Decline Other:_____

Primary Language:_____ Preferred Appt Reminder Method: ☐ Phone ☐ Text ☐ Email

Primary Mailing Address:_____

Zip Code:_____ City:_____ State:_____

Marital Status of Parents: ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Single

Nearest Relative (Not Living With You):_____ Phone:_____

PARENT/GUARDIAN INFORMATION

Financially Responsible Party ☐ Yes ☐ No

Last Name:_____ First Name:_____ Middle:_____

Relationship to Patient:_____ Date of Birth:_____ Sex: ☐ Male ☐ Female

SS #:_____ Drivers License #:_____ State:_____

Primary Mailing Address:_____

Zip Code:_____ City:_____ State:_____

Home Phone:_____ Cell Phone:_____ Email:_____

Employer:_____ Work Phone:_____

PARENT/GUARDIAN INFORMATION

Financially Responsible Party ☐ Yes ☐ No

Last Name:_____ First Name:_____ Middle:_____

Relationship to Patient:_____ Date of Birth:_____ Sex: ☐ Male ☐ Female

SS #:_____ Drivers License #:_____ State:_____

Primary Mailing Address:_____

Zip Code:_____ City:_____ State:_____

Home Phone:_____ Cell Phone:_____ Email:_____

Employer:_____ Work Phone:_____

INSURANCE INFORMATION

Primary Plan Name:_____ Policy Holder:_____ Date of Birth:_____

ID#:_____ Group #:_____ All Children Covered? ☐ Yes ☐ No

Is there other medical insurance coverage? ☐ Yes ☐ No (If Yes, please list secondary insurance information)

Secondary Plan Name:_____ Policy Holder:_____ Date of Birth:_____

ID#:_____ Group #:_____ All Children Covered? ☐ Yes ☐ No

SIBLING INFORMATION

Name:_____ Date of Birth:_____ ☐ Male ☐ Female

Name:_____ Date of Birth:_____ ☐ Male ☐ Female

Name:_____ Date of Birth:_____ ☐ Male ☐ Female

Name:_____ Date of Birth:_____ ☐ Male ☐ Female

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Thank you for choosing our office and allowing us to provide your child's healthcare needs. We are committed to providing the best care for your children. Please read this statement so you will understand your financial responsibility and our payment policy. Care delivered by this facility will be administered regardless of race, color, creed, social status, national origin, handicap or sex. It is our intent to never have the care of our patients compromised for financial reasons. Please contact our billing office to make arrangements if needed.

RESPONSIBILITY FOR THE BILL

All patients and guarantors are financially responsible for timely payment of medical services. We will file insurance claims for payment of the bill(s) as a courtesy to the patient, but the patient/guarantor is ultimately responsible for payment and agrees to pay the account(s).

TIME OF SERVICE COLLECTIONS

Payment for services is expected at the time of the visit. If there is insurance, it is the patient's/guarantor's responsibility to pay their co pay or their portion of the bill at the time of service. If for any reason the co pay is not made at that time, there will be a $5.00 service charge added to the account.

ACCEPTANCE OF INSURANCE

It is the patient's/guarantor's responsibility to understand their own insurance coverage and to schedule their appointments with a doctor who is a provider with their insurance. It is also their responsibility to know where they can go for lab work and other services as referred by the pediatrician. Wasatch Pediatrics will not be financially responsible for outside services. We will be happy to file insurance claims on your behalf.

RELEASE OF INFORMATION

By signing this form, you provide us with the authority to release such information as is necessary to collect from the insurance companies and other third-party payers. You consent to receive calls from Wasatch Pediatrics for your protected healthcare and other services via any information given us by you (verbally or in writing). You may be charged for calls by your wireless carrier and such calls may be generated by an automated dialing system.

BALANCE ON ACCOUNT

Balances are due within 30 days of the insurance payment, unless other satisfactory arrangements have been made with our Business Office. Any balance over 30 days will be charged an interest rate of 1.5% per month (18% APR). Our office cannot become involved with third party liability matters and we will expect payment from the patient/guarantor.

FINANCIAL RESPONSIBILITY OF DIVORCED PARENTS

The parent who seeks medical care for the child is responsible for any unpaid amount. Although divorced parents may have a divorce decree that establishes their financial responsibilities, we are not a party to the decree. We require the parent accompanying the child for treatment to accept primary responsibility for payment of those services. We will bill the parent who brought the child into our office for any unpaid amount. Any responsibility of the other parent, as set forth in the divorce decree, or implied or agreed upon by the parents, will be the responsibility of the parents and we will not be involved.

BAD DEBTS/COLLECTIONS/LEGAL ACTION

Wasatch Pediatrics, Inc. reserves the right to request payment for outstanding balances. In the event any balance is not paid as agreed, the undersigned agrees to pay collection fees, up to 40% of the balance owing. The undersigned also agrees to pay court costs and attorney fees in addition to the collection fee.

CANCELLATION POLICY

Appointments that are not cancelled 24 hours in advance will be charged a fee of up to $100. This fee is your PERSONAL responsibility and not that of your insurance company. The Cancellation Policy also applies to appointments that have been made and then cancelled the same day.

Parent / Guardian Signature

Date

Printed Name

Witnessed by Wasatch Pediatrics Employee