

Jane A. Pardieck, MD, LLC

Date	Insurance card copied
Primary Doctor	Form reviewed by
Form Scanned by	Registration entered by

Patient Name: _____ **Date of Birth:** _____
Preferred Name or Nickname: _____ Male or Female
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: (____) _____ Cell Phone: _____ Email Address: _____

Mother's Name: _____ **DOB:** _____ **SSN:** _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: (____) _____ Cell Phone: _____ Email Address: _____

Father's Name: _____ **DOB:** _____ **SSN:** _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: (____) _____ Cell Phone: _____ Email Address: _____

Primary Insurance / Policy holder's Name: _____ **DOB:** _____ **SSN:** _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: (____) _____ Cell Phone: _____ Email Address: _____
Employer: _____ Work Phone: _____
Relationship to Patient: _____

Secondary Insurance / Policy holder's Name: _____ **DOB:** _____ **SSN:** _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: (____) _____ Cell Phone: _____ Email Address: _____
Employer: _____ Work Phone: _____
Relationship to Patient: _____

Siblings Name: _____ Nickname: _____ DOB: _____ Male or Female
Siblings Name: _____ Nickname: _____ DOB: _____ Male or Female
Siblings Name: _____ Nickname: _____ DOB: _____ Male or Female
Siblings Name: _____ Nickname: _____ DOB: _____ Male or Female

Relative (not living with you): _____ Phone: _____ Relationship: _____

Friend or Neighbor: _____ Phone: _____

Who may we thank for referring you? _____
Address: _____

Release of Medical Info and Authorization to Pay Ins Benefits: I authorize Jane A. Pardieck, MD, LLC to release information from my medical record to my insurance carrier(s), or government agency for the processing of claims for medical benefits. I request that my insurance company(s) honor my assignment of insurance benefits applicable to the services and pay all assigned insurance benefits directly to Jane A. Pardieck, MD, LLC on my behalf.

Consent to Treat: Permission is hereby granted to the physicians to provide and perform such medical/surgical care, tests, procedures, drugs, and other services as are considered necessary or beneficial for the patients/siblings named on this registration. I acknowledge that no representations, warranties or guarantees as to the results or cures have been made to me or are relied upon by me.

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

Jane A. Pardieck, MD, LLC

____ Receipt of Community Health Network Notice of Privacy Practices

____ **Financial Agreement:** I understand all accounts are the full responsibility of the patient and/or the patient's responsible party/guarantor. If the physician is not contracted with my insurance, I understand that payment in full is due at the time of service. My physician's office will assist patients in obtaining insurance benefits when those benefits are assigned to my physician. It is the patient's responsibility to make sure insurance payments are processed and paid promptly to my physician. In the case of default payment, I promise to pay any legal interest on the balance due, together with any collection costs. Collections fees will equal 50% of the amount turned over for collection. Reasonable attorney fees incurred to effect collection of this account or future outstanding accounts will be the responsibility of the patient. We require 100% of copays and deductibles be paid at the time of service regardless of who brings the child to be seen.

____ **Missed Appointments:** Unless canceled at least 24 hours in advance, our policy is to charge \$25.00 for missed appointments. Please help us serve you better by keeping scheduled appointments.

____ **Returned Check Fee:** For any check that is returned, it is our policy to charge a fee of \$25.00.

____ **Release of Protected Health Care Information via Telephone to Answering Machine or Voice Mail:** I give consent and authorization for the Medical, or Billing Staff of my physician's office to leave protected Health Care Information about me or for me on my answering machine or voice mail via the telephone number I have listed below. I understand I may revoke this privilege at any time by submitting my request in writing to this office.

Phone no. _____.

Please list below the names of other parties with whom lab results or appointment information may be left, if we are unable to contact the patient or responsible party.

Name _____ . **Relationship** _____

Phone number _____

Name _____ . **Relationship** _____

Phone number _____

____ **Consent for Treatment:** I understand that my consent is necessary for someone other than a parent or legal guardian to bring my child(ren) to this office for medical care. Understanding that on occasion I may need someone else to bring my children, my completion of the following will allow Jane A. Pardieck, MD, LLC to provide care if this circumstance should occur.

Child: _____ DOB: _____

Child: _____ DOB: _____

Child: _____ DOB: _____

Child: _____ DOB: _____

I, _____ grant permission for Jane A. Pardieck, MD, LLC to provide medical care as deemed necessary to the above named dependent(s) if brought to the office by the persons named below:

Name (Please print) _____

Name (Please print) _____

Name (Please print) _____

Parent/Guardian Signature: _____

Date: _____ Phone no.: _____