

# FAMILY REGISTRATION

FATHER			
Social Security Number	Last Name	First Name	M.I.
Street Address	City	State	Zip Code
		Phone (H)	(C)
Birthday (M/D/Y)	Race	Marital Status	Email
Employer	Occupation	Phone	
MOTHER			
Social Security Number	Last Name	First Name	M.I.
Street Address	City	State	Zip Code
		Phone (H)	(C)
Birthday (M/D/Y)	Race	Marital Status	Email
Employer	Occupation	Phone	
CHILDREN			
Names and Dates of Birth: (indicate M/F)			
Emergency Contact Name:	Phone:	Relationship	
Whom may we thank for referring you to our practice?			

### CANCELLATION POLICY

Your appointment time is important to you, your doctor and to others who are in need of medical care. We charge for missed appointments. Our requested cancellation policy is a 24 hour notice for well child check up visits and consultations (48 hour notice for a double well child check up visit). A \$50.00 fee will be assessed per child for any missed or cancelled appointments without appropriate notice. Your cancellation must be made during regular office hours. You will be personally responsible for this charge. This charge will not be billed to, nor paid for, by your insurance company. As always, emergencies and unforeseen circumstances are taken into consideration.

Signature \_\_\_\_\_ Date \_\_\_\_\_

### HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

Please sign below that you have been offered an opportunity to review a copy of our HIPAA Notice. You are entitled to a personal copy of the notice at any time to keep for your records. If you have any questions about our Privacy Practices, please feel free to contact our Practice Manager, Susan Sevin @ 770-973-4700, ext. 327. Thank you for your cooperation.

Patient Name: *(please print)* \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Signature of Parent/Guardian/Personal Representative: \_\_\_\_\_ Date: \_\_\_\_\_

### FINANCIAL STATEMENT

Patients with managed care insurance (HMO, PPO, POS): Insurance cards must be presented at each office visit in order for us to file your insurance. If you do not have proof of insurance, you may pay for services rendered at the time of service.

I authorize my children to receive health services with the understanding that if our insurance or managed care company determines that their care is a non-covered service, I will be billed and held responsible for services rendered. Co-pays and co-insurance amounts are due at time of service. A billing fee will be applied to any balance not paid at time of service. If a collection agency is utilized to collect delinquent balances, the balance will be increased to include the agency's fee.

I request payment of authorized benefits be made to PAMPA. I authorize any holder of medical information for my family to release information needed to determine benefits payable to related services to PAMPA.

PRINT NAME: X \_\_\_\_\_ DATE: X \_\_\_\_\_

SIGNATURE: x \_\_\_\_\_