Renton Pediatric Associates
PATIENT REGISTRATION

(Please print clearly)

Child's Name: First	Middle	Last	Date of Birth: / / ❑Male ❑Female
Street Address		Apt #	Home Telephone # ( )
City, State, Zip Code			**Race:** ❑ American Indian/Alaska Native ❑Asian ❑African American ❑Caucasian ❑ Other ❑Declined
Language(s) Spoken		**Ethnicity:** ❑ Declined ❑ Hispanic or Latino ❑ **Not** Hispanic or Latino	

Pharmacy Information

Preferred Pharmacy Name:	Phone:	Fax:
Address :	City:	

Parent(s) or Guardian(s) Information

Mother's Name:		Date of Birth	**Father's Name**:		Date of Birth
Address	City	Zip Code	Address	City	Zip Code
Employer:			Employer:		
Social Security #			Social Security #		
Cell Phone #			Cell Phone #		
Work Phone #			Work Phone #		
E-Mail			E-Mail		

Parents: ❑ Married ❑ Divorced ❑ Separated ❑ Single **Child lives with**: ❑Mother ❑Father ❑Both ❑ Other:_____

(Please give Insurance Card to Patient Service Representative to photocopy)

Primary Insurance:	**Secondary Insurance**
Name of Insured Parent:	Name of Insured Parent:
Relationship to Child	Relationship to Child
Insured Parents DOB:	Insured Parents DOB:
Insured Parents Social Security #:	Insured Parents Social Security#:
Is Child covered by Medicaid or Molina? ❑ Yes ❑ No	
If patient is a newborn, have they been added to your insurance? ❑ Yes ❑ No	

Emergency Contact (Nearest Friend/Relative NOT living with child)

Name:	Telephone # ( )	Relation to Child
Street Address:	City, State, Zip Code	

Other Children (to be seen as patients)

First Name	Middle	Last	Date of Birth	❑Male ❑Female
First Name	Middle	Last	Date of Birth	❑Male ❑Female
First Name	Middle	Last	Date of Birth	❑Male ❑Female
First Name	Middle	Last	Date of Birth	❑Male ❑Female

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Renton Pediatric Associates

Payment Policy:
Patients with **no insurance,** or have an **insurance we are not contracted with,** will be required to pay in full at the time of service. If you have insurance but are unable to provide a current insurance card or printed information, you will be considered "Self-Pay" until you provide our office with a copy of your card. Patients with a high deductible will also be expected to pay at time of service. **If, at any time, your account goes to a collection agency, your family will be discharged from the practice.**

REBILLING FEE:
All balances are due and payable within thirty days of the initial statement date. **After thirty days, a $7.50 rebilling fee may be added to your account every thirty days until your balance is paid.** If you are unable to pay the entire amount due, please contact our billing department at (425) 271-5437 and follow the prompts to billing.

Co-pays:
Your insurance requires that we collect your co-pay at the time of service. If you are not prepared to pay your co-pay, we may be required to reschedule your visit. **A fee of $25 is applied for non-payment of co-pay at the time of service if you are seen.**

No Show Policy:

If you fail to cancel an appointment without 24 hours notice, a fee of $30 will be applied to your account. After 3 no-shows, your family will be discharged from the practice.

Insurance:
Your policy is a CONTRACT between you and the insurance carrier. Read it, understand it, and ask questions. DO NOT ASSUME YOUR POLICY AUTOMATICALLY COVERS EVERYTHING. Even different policies from the same insurance company can have different requirements. It is YOUR responsibility to know what your policy covers and what it does not. Always carry your insurance card with you. You will need it for all office visits and may need it in case of an emergency. Some insurance carriers require we verify your coverage for each visit.

I hereby authorize my insurance benefits to be paid directly to Renton Pediatric Associates. I have read and understand the Renton Pediatric Associates Financial Policy. I am responsible for the payment of any deductibles and co-pays associated with my plan and any other balances due after my insurance has processed my claim. I authorize Renton Pediatric Associates to release any and all personal health care information necessary to process an insurance claim. I also understand that if my insurance company denies a charge for any reason, I will be billed and ultimately responsible for that charge. In addition, if a claim is disputed by the insurance company for any reason, and payment has not been made in a timely manner, I will be responsible for the payment on the charges in question. In event of default for any reason, parent/guardian is responsible for any and all attorney fees, collection fees and all court costs.

Signature: _____ Date: _____

Notice of Privacy Practices – Acknowledgement

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask us to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting the Practice Administrator at (425) 271-5437.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

Signature: _____ Date: _____

Printed Name: _____ Relationship to Patient: _____