Renton Pediatric Associates
PATIENT REGISTRATION

(Please print clearly)

Child's Name: First Middle Last	**Date of Birth:** / / ❑Male ❑Female
Mailing Address Apt #	**Child's Cell Phone**(over 13 years old)
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	

Appointment Reminders are a courtesy, you are still responsible for keeping your appointment

Renton Pediatrics may text courtesy appointment reminders to the phone number provided here. ☐ Phone Number: Signature:	☐ I DO NOT approve courtesy reminders via text message

Pharmacy Information

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

Parent(s) or Guardian(s) Information

Primary Parent/Guardian's Name: Date of Birth	**Secondary Parent/Guardian's Name**: Date of Birth
Address (If different from child) City Zip Code	Address(If different from child) City Zip Code
Employer:	Employer:
Home Phone #	Home Phone #
Cell Phone #	Cell Phone #
Work Phone #	Work Phone #
E-Mail	E-Mail

Parents: ❑ Married ❑ Divorced ❑ Separated ❑ Single **Child lives with**: ❑Primary Parent ❑Secondary Parent ❑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 ID #:	Insured Parents ID #:
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

Please continue on other side

Payment Policy: Patients with **no insurance,** or have **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. An additional fee of $25 is applied for non-payment of co-pay at the time of service.

No Show Policy: *If you fail to cancel an appointment* without *24 hours' notice, a fee of $40 for an office visit and a fee of $50 for a Well Child Checkup will be applied to your account. After 3 no-shows, your family will be discharged from the practice.*

Nurse Call Service: After regular business hours, our office utilizes a Nurse Call Service. After two calls to the nurse service in a given month, there will be a charge of $20 for each additional call per month.

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.

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:_____

Patient Name _____

Renton Pediatric Associates
FINANCIAL POLICY

Thank you for trusting us to provide medical care to your child. We appreciate the opportunity to provide you superior medical care and customer service. We are concerned about the ever-rising cost of health care and are dedicated to holding down costs to our patients. Our staff of physicians and healthcare providers are committed to your successful treatment and well-being.

Please read the following financial policy and information carefully and sign at the bottom of the page prior to treatment. If you have any questions, please ask for clarification. Every parent is requested to sign this form for each child before we can provide services.

Upon check-in for an appointment you will be asked to produce a valid ID and current insurance cards.

RESPONSIBLE PARTY

You are responsible for paying for the services that are provided to you by our healthcare providers. If the patient is a child, the responsible party will be the biological parent or legal representative seeking medical care for the child. If a party is authorized by signed consent, the responsible party authorizing the consent will be liable for the services. Renton Pediatric Associates is not obligated to follow civil court decisions, including financial obligations for divorced decrees or parenting plans.

UNDERSTANDING YOUR BENEFITS

Please familiarize yourself with your insurance benefits and verify that the provider you are seeing is part of the preferred provider network. Your health plan mandates that you are financially responsible for payment of all copays, deductibles, and non-covered services and Renton Pediatric Associates is contractually obligated to collect them. We do not verify insurance benefits, which is why we highly recommend that you contact your insurance company and familiarize yourself with your policy's benefits.

UNDERSTANDING OUR CHARGES

Patients will be charged for each service that is performed during the course of an office visit. Included in the base charge for an office visit are a discussion about the nature of the illness, and examinations of the patient, medical decision making, development of a treatment plan, and discussion with the patient about the plan. Other activities (procedures) are billed in addition to the charge for the examination. These charges might include- but are not limited to – sutures, wart removal, vision and hearing tests, removing wax or foreign bodies from the ears or nose, lab tests, administrations of immunizations, and other additional services. It is Renton Pediatric Associates policy that medical staff members do not quote fees for services or supplies, but you may ask the provider or MA to contact the billing office to learn the exact cost of the procedure, test or lab service before it is provided.

Patient Name _____

CO-PAYMENTS

Co-payments are due at the time you check in for your appointment. This is also expected if an authorized party brings the child in. There will be a $25 fee added to your account if the co-payment is not made at check-in.

BILLING STATEMENTS

Our office is contracted with many insurance carriers. If we are contracted with your insurance company, you will receive a billing statement from us after the insurance has processed your claim. Your charges will be listed along with any payments received from your insurance company.

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.

No Show Policy:

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RETURNED CHECKS

A returned check fee of $35 will be charged to your account for each returned check.

PAYMENT OPTIONS

Renton Pediatric Associates accepts cash, money orders, VISA, Mastercard and Discover. Credit card payments can be made in person, by mail or over the phone by calling (425) 271-5437 and following the prompts to billing.

COLLECTIONS

Every attempt will be made to collect your account. In the event that your unpaid account is sent to an outside collection agency, Renton Pediatric Associates may permanently discontinue providing medical care for any current or future family members.

_____ _____

Signature Date

_____ _____ _____

Printed Name Patient Name Patient Date of Birth

RENTON PEDIATRIC ASSOCIATES **Date:** _____

CHILD AND FAMILY HEALTH HISTORY FORM

CHILD'S NAME: _____ DATE OF BIRTH:_____ AGE:_____
CHILD'S PREVIOUS DOCTOR/PRIMARY CARE PROVIDER: _____
PRESENT HEALTH CONCERNS: _____
_____
MEDICINES/VITAMINS: _____
HERBS/HOME REMEDIES: _____
ALLERGIES/REACTIONS TO MEDICINES OR VACCINATIONS: _____
_____

PREGNANCY & BIRTH

Where was your child born? _____
Is the child yours by: ☐Birth ☐Adoption ☐Stepchild ☐Other: _____
Please indicate any medical problems during pregnancy ☐None ☐Specify: _____
_____

Delivered by ☐ Vaginal Birth ☐Caesarean If Caesarean, why? _____
Birth weight: _____ Birth length: _____ APGAR score 1 min _____ 5 min _____
Please indicate any medical problems during the baby's newborn period ☐ None If premature, how early: _____
Other problems: _____

NUTRITION & FEEDING

Was your child breastfed? ☐No ☐Yes If so, how long? _____
Has your child had any unusual feeding/dietary problems? ☐No ☐Yes If yes, specify: _____
_____
Milk intake now: Type ☐Cow's milk (☐ Nonfat ☐1% fat ☐2% fat ☐Whole milk) ☐Soy milk ☐Rice milk
Average ounces per day (Note: 8 ounces = 1 cup) _____

SLEEP

Hours per night _____ Naps (number & length) _____
Any sleep problems? _____

DEVELOPMENT

At what age did your child: Sit alone _____ Walk alone _____ Say words _____ Toilet train (daytime) _____
Girls only: Age at first menstrual period_____

DENTAL HISTORY: Has child been seen by a dentist? ☐ No ☐ Yes If so, how often?_____ Date of last visit _____

***IMMUNIZATION/INFECTIOUS DISEASES**: Please bring your child's immunization records to your appointment.
Has your child had: ☐Chickenpox ☐Measles ☐Mumps ☐Rubella ☐Meningitis ☐Tuberculosis (TB)

EXPOSURES/HABITS: Any concerns about lead exposure? (old home/plumbing/peeling paint) ☐No ☐Yes
Do any household members smoke? ☐No ☐Yes
TV-hours per day _____ Computer-hours per day _____ Video games-hours per day _____

PAST MEDICAL HISTORY: Please describe any major medical problems and their dates.
_____
_____
_____

Hospitalizations/operations (with dates):
_____
_____

Broken bones or severe sprains:
_____

(Turn page over and complete the other side)

FAMILY HISTORY:

Please indicate with a check (☑) family members who have had any of the following conditions:

Medical Condition	Mom	Dad	Sister	Brother	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	Mom's Sister	Mom's Brother	Dad's Sister	Dad's Brother
Alcoholism												
Anemia												
Asthma												
Autoimmune Disorder												
Bleeding Disorder												
Cancer, Breast												
Cancer, Melanoma												
Cancer, Ovary												
Congenital Anomaly/Birth Defect												
Heart Attack/Heart Disease												
Depression												
Diabetes, on insulin shots												
Diabetes, not on insulin												
Eczema												
Food Allergy												
Genetic Disorder												
Hay Fever												
Hearing Disorder												
High Cholesterol												
High Blood Pressure												
Immune Disorder												
Kidney Disease												
Mental Retardation or Learning Disability												
Stroke												
Substance Abuse												
Thyroid Disorders												
Tobacco Use												
Tuberculosis												
Death before age 56 for reason not listed												
Other:												
Other:												

SOCIAL HISTORY

Who lives at home?

Name Age Relationship Highest Education Level

_____

_____

_____

_____

_____

Are your child's parents ☐Married ☐Unmarried ☐Separated ☐ Divorced If divorced or separated, when? _____

Mother's Occupation _____ Mother's Employer _____

Father's Occupation _____ Father's Employer _____

Childcare situation ☐Parents ☐Others (specify who and hours per day) _____

Concerns about your child: ☐Alcohol use ☐Tobacco ☐Sexual activity ☐Aggressive behavior

Is violence at home a concern? ☐No ☐Yes Are there guns in the home? ☐No ☐Yes

SCHOOL HISTORY

Did/does your child attend school or preschool? ☐No ☐Yes

Current Grade _____ Name of School _____

Any concerns about school performance? _____

Any concerns about relationships with Teachers ☐No ☐Yes Students ☐No ☐Yes

If more than 4 years old: does your child have a best friend? ☐No ☐Yes

Sports/exercise: Type _____ How often? _____ How long (minutes) _____

Authorization for Health Care of a Minor

Patient Name _____ Date of Birth _____
Last First MI mm/dd/yyyy

I, the parent or legal guardian of the minor child listed above, hereby authorize the persons listed below to make health care decisions for my minor child. I understand all copay's must be paid at time of service or there will be a billing fee of $25 charged to my account. I also understand whoever brings my child in will be expected to present valid identification and also copies of insurance cards.

_____ _____
Signature Date

_____ _____
Print Name Relationship to Minor (parent, guardian, or other legally authorized person)

_____ _____
Address: Street or P.O. Box City, State, Zip

_____
Phone

AUTHORIZED PERSONS <u>(Other than Parents or Legal Guardians)</u>

Name_____ Relationship to Child_____

Name_____ Relationship to Child_____

Name_____ Relationship to Child_____

Name_____ Relationship to Child_____

Name_____ Relationship to Child_____

This declaration is effective for no longer than one year from the date on which it is signed, or until revoked in writing by the parent or legal guardian.