



Patient Registration

New Patient Update only

PID#: _____

Cards scanned: _____

Patient registration entered by: _____

Have we seen you in the last three years? Yes No Previous name _____

Patient Information:

Name: Last _____ First _____ MI _____
 Patient's Social Security #: _____ - _____ - _____ Date of Birth _____ Gender _____
 Marital Status _____ Race _____ Parent/Guardian Driver's license # _____ State: _____
 Email Address: (used for updates about GNP services and locations) _____
 Primary care physician (PCP) _____ Phone: (____) _____
 Primary care physician address: _____
 How did you hear about us? _____

Parent / Legal Guardian Information (address 1)

Name: Last _____ First _____ MI _____
 Street address _____ Apt # _____
 City _____ State _____ Zip code _____
 Phone: Home (____) _____ Cell (____) _____ Work (____) _____
 Social Security #: _____ - _____ - _____

Person to contact in case of an emergency if unable to reach the parent/legal guardian listed above.

Name: _____ Phone: (____) _____
 Relationship to patient: _____ Address: _____

Patient school / employer information

School / Employer: _____ Occupation _____
 Address: _____ Phone: (____) _____

*Primary Insurance: Although we scan your insurance cards not all the information necessary to file a claim is on the card. Please complete the policy number, policyholder name, DOB, gender, relationship to patient and employer. For military coverage, we also need the branch, status, and rank. **If the information is not complete, the account will be set as self-pay until we have the information necessary to file a claim.***

Plan Name: _____ Plan Type: _____
 Co-Pay _____ Effective date: _____ verified by: (internal use only) _____
 Subscriber Number: _____ Group Number: _____
 Claims address: _____
 Policy Holder Last: _____ First: _____ MI: _____ DOB: _____
 Gender: _____ Relationship to patient: _____ Employer: _____
 Military Branch: _____ Status: _____ Rank: _____

Secondary Insurance:

Plan Name: _____ Plan Type: _____
 Co-Pay _____ Effective date: _____ verified by: (internal use only) _____
 Subscriber Number: _____ Group Number: _____
 Claims address: _____
 Policy Holder Last: _____ First: _____ MI: _____ DOB: _____
 Gender: _____ Relationship to patient: _____ Employer: _____
 Military Branch: _____ Status: _____ Rank: _____

Other information:

List any allergies to food or drugs: _____
 Primary language: _____ Religion: _____
 Printed name of Guarantor _____
 Relationship to patient: _____ Date completed: _____

AUTHORIZATION TO RELEASE INFORMATION:

I authorize Good Night Pediatrics to disclose all or any part of the patient’s medical record and/or clinic charges (including information regarding alcohol or drug abuse, psychiatric illness or communicable disease related information including HIV) to any person or corporation (i) which is or may be liable or under contract to Good Night Pediatrics for reimbursement, subrogation and/or direct recovery and coordination of benefits for this and all future claims including but not limited to hospital/medical service companies, workers’ compensation carriers, welfare funds, governmental agencies and (ii) any health care provider for continued patient care. Good Night Pediatrics may also disclose on an anonymous basis any information concerning the patient’s case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, statute or regulation. Except, as above, Good Night Pediatrics will require the patient’s, or in the case of a minor child, a natural parent or legal guardian’s, written consent to release information about the patient. I also agree that in all instances, the original medical records (including x-rays and laboratory specimens) remain the property of Good Night Pediatrics.

Guarantor Signature: _____ Date: _____

Please sign only 1 of the 2 following paragraphs. The first allows us to bill your insurance and must be signed in order for us to file a claim for your benefits. The second is stating that you do not want your insurance billed if you have coverage and that you will be paying for the services.

ASSIGNMENT OF BENEFITS

In the event the patient, his/her authorized representative or the guarantor signing below, is entitled to benefits of any type arising out of any policy of insurance insuring the patient or any other party liable to the patient, those benefits are hereby assigned to Good Night Pediatrics for application against the patient’s bill. Such payment shall discharge that insurance company of any obligation under the policy to the extent that payment has been made correctly according to the terms of the policy. The undersigned shall remain responsible for any and all charges not paid by the insurance company and/or not covered by this assignment. For any Medicare eligible coverage, I request that payment of any authorized Medicare benefits be made on my behalf; I assign the benefits payable for physicians’ services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for Payment. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, is hereby assigned to Good Night Pediatrics or to the provider group rendering service for application to patient’s bill.

Guarantor Signature: _____ Date: _____

WAIVER OF ASSIGNMENT OF BENEFITS

I understand by not signing the above assignment of benefits, I will be responsible at the time of service for 100% for all charges incurred. I also understand that there may be additional charges that may not be available at the time for service that will be billed to me.

Guarantor Signature: _____ Date: _____

FINANCIAL RESPONSIBILITY

I agree that in return for the services provided to the patient by Good Night Pediatrics, or other health care providers, I will pay the account of the patient prior to discharge or make financial arrangements satisfactory to Good Night Pediatrics or any other providers for payment. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney’s fees as established by the court and not by a jury in any court action. A delinquent account may be charged interest at the legal rate. IT IS UNDERSTOOD THAT THERE MAY BE ADDITIONAL CHARGES FOR X-RAY AND LABORATORY TESTS PERFORMED BY PROVIDERS OR ORGANIZATIONS OTHER THAN GOOD NIGHT PEDIATRICS THAT WILL BE BILLED SEPARATELY.

Guarantor Signature: _____ Date: _____

If you would like a copy of this agreement, please request one from the front office when you return your paperwork to them.



CONSENT TO TREAT A MINOR

By signing below, I state that I am the natural parent or legal guardian having legal custody of _____, a minor, and age _____, born on _____. I give permission for Good Night Pediatrics Inc., in the County of Clark, State of Nevada, to perform or administer x-ray, examination, anesthetic, medical or surgical diagnosis and/or treatment under the general or special supervision and on the advice of any physician or surgeon licensed in the State of Nevada, when the need for such treatment is clear, and when efforts to contact me are unsuccessful.

This authorization shall remain effective for one (1) year from the date of signature unless sooner revoked in writing and delivered to Good Night Pediatrics.

Guarantor Signature: _____ Date: _____

Witness Signature: _____ Date: _____

The portion below is only to be completed if a parent or legal guardian is not present with the minor child at the time of service.

TELEPHONE AUTHORIZATION FOR CONSENT TO TREAT

Date: _____ Time: _____

Reason for acquiring telephone permission: _____

Telephone number called: (____) _____ With whom did you speak? _____

How did s/he identify her/himself? _____ Relationship to patient: _____

Explanation to patient _____

Her/his reply _____

Signature of person placing the call: _____

Printed name of person placing the call: _____

Signature of witness to the call: _____

Printed name of witness to the call: _____



PATIENT ACKNOWLEDGMENT FORM

Our Notice of Privacy Practices provides information about the privacy rights of our patients; and how we may use and disclose protected health information (PHI) about our patients. Federal regulation requires that we give our patients or their authorized representative the opportunity to review our Notice before signing this acknowledgment. A one-page summary of our Notice is displayed in our office. A copy of our Notice will be made available to you at your request.

If you have any questions about your rights or our privacy practices please send a letter to:

Privacy Officer
Good Night Pediatrics, Inc.
7720 N 16th Street, Suite 425
Phoenix, AZ 85020-4492

We will respond to your within five (5) business days.

By signing this form you acknowledge only that we have provided you with immediate access to our Notice of Privacy Practices.

Signature of Patient or Authorized Representative

Date

Print Name of Patient

Print Name of Authorized Representative