Center City Pediatrics

Today's Date: _____

PATIENT REGISTRATION PACKET

PLEASE BE SURE TO PRINT CLEARLY TO ENSURE ACCURATE INFORMATION

Childs Name LEGAL FIRST AND LAST NAME	Childs Date of Birth MONTH, DAY AND YEAR	Childs sex MALE OR FEMALE

Main Phone Number: _____

(Note that the phone number listed above will receive the reminder phone calls prior to ANY appointments made for your child (ren).)

Parent/Guardian Information #1:

Name:_____Date of Birth: _____

Please circle one: Male or Female

Cell Phone Number: _____

Email: _____

Please Circle One: I DO I DO NOT Consent to correspond through E-Mail

Relationship to child (ren): _____

Please Circle One: I DO I DO NOT give permission for CCP to use the above information to send me an invite to join the online health record (FMH) for my child (ren) as a "proxy".

Center City Pediatrics

Parent/Guardian Information #2:

Name:_____Date of Birth: _____

Please circle one: Male or Female

Cell Phone Number: _____

Email: _____

Please Circle One: I DO I DO NOT Consent to correspond through E-Mail

Relationship to child (ren): _____

Please Circle One: I DO I DO NOT give permission for CCP to use the above information to send me an invite to join the online health record (FMH) for my child (ren) as a "proxy".

General Information:

Home Street Address:_____APT/UNIT: _____

City:_____State:_____Zip: _____

Preferred location: (Please circle one)
Center City (Main Office) OR Bala Cynwyd (Satellite Office)

Preferred Caregiver: (Please circle one)

Dr. Berger Dr. Warren Dr. Madani Dr. Fischer Dr. Robinson

Dr. Frost Dr. Lee Dr. Barkan

Referred By: (Please circle one)
Friend Hospital OB-GYN Internet Other: _____

Center City Pediatrics

Race: (Please circle one)
White Black Asian American Indian/Alaskan Native Other:_____

Preferred Language:_____Do you understand English? Yes or NO

Ethnicity: (Please circle one) Hispanic/Latino Non-Hispanic/Non-Latino

PHARMACY

What is the name of the pharmacy you use? _____

Address: _____

Phone Number: _____

INSURANCE INFORMATION

Name of Primary Insurance: _____

Identification Number:_____Group #: _____

Subscriber Name:_____Date of Birth:_____

Does your child (ren) have a second insurance? ( ) Yes ( ) No

Name of Secondary Insurance: _____

Identification Number:_____Group #: _____

Subscriber Name:_____Date of Birth: _____

Center City Pediatrics

Name of personal responsible for the bills of the house, note that this parent/guardian will receive/if applicable statements/bills from our office:

Print parent/guardian name: _____

Release and Assignment:

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicaid, Blue Shield, HMO Plans, and Commercial Insurance to Center City Pediatrics. I understand that I am financially responsible for all charges whether or not covered by insurance. I hereby authorize and designee to release any information to secure payment.

Signature: _____ _____

Patient or Patient Representative/Parent *Date*

Financial Responsibility:

I understand that payment of all medical care is due and payable at the time of service. With dependents of divorced parents, responsibility and payments shall be that of the guardian bringing the child for treatment. I understand that it is my responsibility to pay any deductible, co-insurance, or any other balance not paid by my insurance company. I understand that I am responsible for any costs incurred in the collection of patient's accounts in case of default including reasonable attorney fees and court costs. I hereby grant permission to Center City Pediatrics to release any pertinent information to my insurance company upon request; I also authorize payment directly to Center City Pediatrics. A photocopy of this authorization shall be considered as effective and as valid as the original.

Signature: _____ _____

Patient or Patient Representative/Parent *Date*

Center City Pediatrics

HIPAA Privacy Practices Acknowledgement Form:

I have been provided with a copy of the Notice of Privacy Practices for Center City Pediatrics to review and by my signature below acknowledge that I have reviewed it.

Signature: _____ _____

Patient or Patient Representative/Parent *Date*

Appointment/No Show Policies:

I have received a copy of the Center City Pediatrics Appointment and No Show Policies. I understand that Center City Pediatrics has the right to change its appointment policy from time to time. I have reviewed and had the opportunity to ask questions about the Appointment and No Show Policies.

Signature: _____ _____

Patient or Patient Representative/Parent *Date*

Center City Pediatrics

CONSENT FOR TREATMENT OF A MINOR CHILD

It is the policy of Center City Pediatrics, LLC that any new patient under the age of 18 must be seen in the presence of their parent or legal guardian for their first visit. An established patient [a patient known to the practice and seen within the past 12 months] may be brought in by an adult if written permission is given by the parent or legal guardian and that person shows valid photo ID. By filling out the form below you are giving consent for the adult(s) listed to bring your child in for their Center City Pediatrics appointment(s) in your absence. We will include this form in your child's file.

I_____for_____

(Print Your Name) (Child's Name)

Hereby voluntarily consent to the following person to being my child to their appointments at Center City Pediatrics:

Name:_____relationship to child (ren): _____

Name:_____relationship to child (ren): _____

Name:_____relationship to child (ren): _____

_____ _____

(Parent's Signature) (Child's Date of Birth)

_____

(Date)

This form will need to be updated 1 year from now