HAMDEN PEDIATRICS 2022 FAMILY REGISTRATION FORM

Parent/Guardian #1:

Name: _____ Birth Date: _____

Permanent Address: _____ Home Phone: _____

Email Address: _____Cell Phone: _____

What is the best phone number to confirm appointments? _____

Parent/Guardian #2:

Name: _____ Birth Date: _____

Permanent Address: _____ Home Phone: _____

Email Address: _____Cell Phone: _____

Insurance Information: We will also need to keep a copy of the card on file for billing purposes

Primary Insurance: _____ ID #: _____

Subscriber's name: _____ Group # _____

Subscriber's DOB:_____Co-Pay Amount listed on card: _____

Secondary Insurance: _____ ID #: _____

Subscriber's name: _____ Group # _____

Subscriber's DOB:_____Co-Pay Amount listed on card: _____

Children (Please list Oldest to Youngest)

Name/Sex	Resides with Parent 1, 2, or both	Birth Date	Race/Ethnicity	Cell Phone number (children 16+)

Please turn over

Release of Information

I authorize my physician, health care provider, and their representatives to release information relating to an illness, injury, diagnosis, care, or treatment to my insurance company, health plan, Medicare, Medicaid, or third party payor or their agents, contractors, subcontractors, or affiliates, schools and camps, provided they agree such information is kept confidential. Such information shall include, but is not limited to any medical records and medical information, including immunization information. I understand that the reason for furnishing such information may include the following: for use in medical, financial, or physician auditing, or other such auditing, as may be legally required, for utilization and/or quality of care review and assessment for determining available health benefits and coverage.

X_____ _____

Parent/Guardian/Patient Signature Date

I AUTHORIZE DIRECT PAYMENT OF MEDICAL BENEFITS TO HAMDEN PEDIATRICS FOR HEALTHCARE SERVICES MY CHILD RECEIVES (CHILDREN RECIEVE).

X_____ _____

Parent/Guardian/Patient Signature Date

No-Show Policy

Quality Care for our patients is our priority. When a patient does not show up for a scheduled appointment, another patient loses an opportunity to be seen. Please take a few minutes to review our no show policy and sign at the bottom of the form. If you have any questions, please let us know.

Definition of a No-Show

A missed appointment is defined as any scheduled appointment in which the patient either:

- Does not arrive to the appointment
- Cancels with less than 24 hours notice
- Arrives more than 10 minutes late and consequently is unable to be seen

Impact of a No-Show Appointment

No-Show appointments have a significant negative impact on our practice and the healthcare we provide to our patients. When a patient “no-shows” a scheduled appointment it:

- Potentially jeopardizes the health of the “no-showing” patients
- Is denying appointments to other patients in need of care.

How to Avoid a No-Show Appointment

- As a courtesy, we confirm appointments 2-3 days prior to scheduled appointments
- Give at least 24 hours notice if you need to cancel
- Arrive 5-10 minutes early to your appointment

Consequences of a No-Show Appointment

- It is our policy to charge $30.00 for a missed appointment. These charges are not covered by insurance.
- In addition to these charges, we reserve the right to dismiss patients from our practice after three missed appointments (in a 12 month period).

X_____ _____

Parent/Guardian/Patient Signature Date