

Riverdale Park Pediatrics, P.C
Patient Registration Form

Today's Date: _____

Patient Information

Name: _____

Date of birth: _____ Social Security # _____ Sex: __ M __ F

Home Address: _____

City: _____ State: _____ Zip Code _____

Parent / Guardian Information

Mother's Name: _____ Date of birth: _____

Cell Phone: _____ Work Phone: _____

Home Address (if different from child) _____

City: _____ State: _____ Zip: _____

Email address: _____ Social Security # _____

Father's Name: _____ Date of birth: _____

Cell Phone: _____ Work Phone: _____

Home Address (if different from child) _____

City: _____ State: _____ Zip: _____

Email address: _____ Social Security # _____

Emergency Contact: (relative or friend): _____ Phone#: _____

Insurance Information

Primary Insurance: _____ Policy # _____

Group # _____ Subscriber Name: _____

Subscriber DOB: _____ Subscriber Social Security# _____

Patient relationship to subscriber: _____ Employer: _____

Employer Address _____

Employer phone # _____

Secondary Insurance: _____ Policy # _____

Group # _____ Subscriber Name: _____

Subscriber DOB: _____ Subscriber Social Security# _____

Patient relationship to subscriber: _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Riverdale Park Pediatrics or insurance company to release any information required to process my claims.

Patient/Guardian signature _____ Date _____

Riverdale Park Pediatrics, P.C
6103 Baltimore Ave. T-1
Riverdale, MD 20737
Phone (301) 277-2779 Fax (301) 277-6947

CONSENT FOR TREATMENT OF A MINOR

I, _____ The parent or guardian of

_____, who i.e. a minor, authorize **Riverdale Park Pediatrics, P.C** and all persons acting as agents thereof and all physicians to whom said minor is referred for medical treatment, to furnish all forms of diagnostic, preventative and medical treatment to said minor. This consent shall remain in effect until a written revocation hereof is delivered to **Riverdale Park Pediatrics**.

AUTHORIZATION AND RELEASE

I authorize **Riverdale Park Pediatrics** to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to **Riverdale Park Pediatrics** insurance benefits otherwise payable to me.

PAYMENT POLICY

I understand that if **Riverdale Park Pediatrics/ Edwin Aguilar, M.D** is not contracted with my insurance carrier, I must pay in full at the time of service. I understand that my insurance carrier may pay less than the actual bill for services. I also understand that some services provided by **Riverdale Park Pediatrics, P.C** may not be covered by my benefit plan. I agree to be responsible for payment of all services rendered. I understand that all Co-payments, Co-insurance and Deductibles are due at the time of service. I understand that any balance generated is due within 10 days of the billing day unless other arrangement is made. I realize that failure to keep this account current may result in **Riverdale Park Pediatrics**, being unable to provide additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect this amount or any future outstanding balances.

NEW BABY

I fully understand that my newborn baby needs to be added to my insurance policy by the two-week appointment. If my newborn baby has not been added to the policy or does not have health insurance, I am aware that I am responsible for the office fee at the time services are rendered.

I HAVE READ AND UNDERSTAND THE INFORMATION ON THIS FORM, NAMELY THE SECTIONS TITLED: CONSENT TO TREATMENT OF A MINOR, AUTHORIZATION AND RELEASE AND PAYMENT POLICY. I AM THE PARENT OF SAID MINOR CHILD, OR THE COURT-APPOINTED GUARDIAN FOR THE PATIENT AND I AM AUTHORIZED TO ACT ON THE PATIENT'S BEHALF TO SIGN THIS RELEASE OF INFORMATION.

SIGNATURE OF PARENT OR GUARDIAN OF PATIENT

DATE

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Medical Treatment Authorization

Date: _____

I _____ authorize the following people to bring my child _____ in for treatment in my absence, He / She is empowered to make medical treatment decisions while I am absent and to sign any and all medical paper work so that my child may receive proper and prompt medical treatment.

This notice is valid until I provide another written notice stating otherwise, or until I am present to make these decisions myself.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Sincerely,

Parent/Guardian Name

Parent/Guardian Signature

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certification.

I have received, read, and understand your Notice of Privacy Practices that contains a more complete description of the uses and disclosures of my health information. I understand that Riverdale Park Pediatrics P.C has the right to change its notice of Privacy Practices from time to time and that I may contact Riverdale Park Pediatrics, P.C at any time in writing at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that you are not required to agree to my requested restrictions if it not feasible for RPP, PC to ensure compliance or believe it will negatively impact the care Riverdale Park Pediatrics provides.

Patient's Name: _____

Date of Birth: _____

If patient under 18 years old parent or legal guardian signature required.

