KENSINGTON – GAITHERSBURG

Registration Form

Name of person filling form: _____ Relationship to Child: _____
(If you are not the child's parent or legal guardian please inform parent they must be present to sign legal documents)

A. PATIENT INFORMATION (Use name on birth certificate or insurance)

Child's Last Name: _____ Date of Birth _____/_____/_____
Child's First Name: _____ Gender (Circle One) GIRL/BOY
Child's Middle Name: _____ Language _____
Address _____Apt#_____ Race(s) or ethnic background(s) _____
City_____ State _____ Telephone #: _____
Zip Code _____

MOTHER/GUARDIAN #1 Information □ Step-Parent □ Other _____

Last Name _____ Home #: _____
First Name_____ Work #: _____
Address (If different than child's) _____ Cell #:_____
_____ Email: _____
_____ Employed by: _____
DOB _____/_____/_____ SSN_____

FATHER/GUARDIAN #2 Information □ Step-Parent □ Other _____

Last Name _____ Home #: _____
First Name_____ Work #: _____
Address (If different than child's) _____ Cell #:_____
_____ Email: _____
Employed by _____
DOB _____ SSN _____

B. Preferred Emergency Contact (Must be different from above in section A)

Last Name _____ Relationship to Child: _____
First Name_____ Phone #: _____
Address (If different than child's) _____ Email: _____
_____
_____

SIBLING(S)

Sibling#1:_____ DOB: _____/_____/_____
Sibling#2:_____ DOB: _____/_____/_____
Sibling#3:_____ DOB: _____/_____/_____

Authorized to bring patient to office, discuss medical information and make medical decisions?

Person #1: _____
Person #2: _____
Person #3: _____

C. INSURANCE

Child's Medicaid Number (red & white card) _____
Child's MCO: _____ MCO ID Number: _____
We ONLY participate with: Amerigroup, Priority Partners, AND Riverside MCOs.

Is your child covered by any other insurance (private insurance through a job, parent or spouse, etc.)? ***YES/NO***
*** PLEASE NOTE According to Maryland Medicaid: If you have any other medical insurance, Medicaid is always the payer of last resort and your private policy will be billed first, provided that benefits are properly coordinated. You must disclose your primary insurance to Medicaid**. If you fail to report any other insurance, and visits are retracted, you will be responsible for your child's balance.

D. PRIVATE INSURANCE

Primary Insurance Name _____ Subscriber ID # _____
Subscriber Name _____ Employers Name _____
(Person who enrolled into health plan) Employers Phone # _____
Subscriber DOB _____/_____/_____ Subscriber SSN _____
Relationship to patient: _____

Secondary Insurance Name (if other than Medicaid) _____
Subscriber Name _____ Subscriber ID # _____
(Person who enrolled into health plan) Employers Name _____
Subscriber DOB _____/_____/_____ Employers Phone # _____
Relationship to patient: _____ Subscriber SSN _____

E. CONSENT & AGREEMENT

I hereby consent to the use and disclosure of my child's Private Health Information (PHI) and Individually Identifiable Health Information (IIHI) for payment, treatment and other healthcare operations, according to the Health Insurance Accountability and Portability Act of 1996, effective April 14, 2003. I have been given an opportunity to review a copy of the Privacy Notice. I have reviewed the Children's IQ Network (CIQN) Information Sheet. I understand that patient information will still be stored electronically for my provider's records, and that an electronic health summary will be available to other providers through the CIQN. I also understand that I have the right to not share (opt-out) health information with other providers within the CIQN. (Please request a form if you'd like to opt out)

I hereby authorize the release of pertinent medical information to insurance carriers and authorize my insurance benefits to be paid directly to International Pediatrics, PA, realizing that I am responsible to pay unpaid services. The medical services will be submitted to my insurance company based on the information I have provided. If payment has not been received within 60 days of service OR payment has not been received due to incorrect insurance information being given to International Pediatrics, PA at time of service, the account will be turned over to an outside collection agency with additional fees added.

The undersigned hereby consents to the administration of such medical treatment, diagnostic and/or therapeutic procedures and surgery as required by the physician rendering care for themselves and/or their child(ren).

Parent/Guardian Signature: _____ Today's Date _____/_____/_____

Parent/Guardian Print Name _____