Randolph Pediatrics

Patient Registration

Patient Name: ______________________________ **DOB:** ________________ **Sex: M / F**

Mother's Name: ______________________________________ DOB: ______________

Address: ___________________________________ Email: _____________________
(Street) (City/Zip)

Home#: __________________ Cell#: ____________________ Work: _________________

Father's Name: ______________________________________ DOB: ______________

Address: ___________________________________ Email: _____________________
(Street) (City/Zip)

Home#: __________________ Cell#: ____________________Work: _________________

Please list any Allergies, Medications or Medical Conditions:

____

Please list siblings.

Name	DOB
____________________	_____________
____________________	_____________
____________________	_____________

Guardian (if different from above)

Name/Address: ____

Phone #: ______________________

Insurance

Carrier: ____________________________ Member ID: __________________________

Group #: ______________________ Name of Subscriber: __________________________

Party responsible for payments: ____

****We do not submit to Secondary Insurance. This is the responsibility of parent/guardian****

Whom may we thank for referring you to our office? ___________________________________

Marisa Ciufalo, MD • 711 Route 10 E • Randolph • NJ • 07869
973-328-9200 • forms@randolphpediatrics.com

Financial Policy

Patient Name: ____ DOB: _________________

We are committed to providing the best possible care for our patients. Your clear understanding of our financial policy is important to our professional relationship.

The benefit packages provided by insurance companies vary employer to employer. Medical insurance is a contract between you, your employer, and your insurance company. Not all services are a covered benefit in all contracts. You need to learn the benefits of your policy and follow the rules of your policy.

The accompanying parent or adult is responsible for all copays and balances due at the time of service and must have the proper insurance card. Our office will not get involved in divorce settlements. The parent bringing in the patient is financially responsible.

Broken appointments are a cost to us, to you, and other patients who could have used the time set aside for your appointment. Please call us at least 24 hours in advance to make scheduling changes. We reserve the right to charge a $50.00 fee to your account if we find that you continue to miss appointments without advance notice. Excessive missed appointments may result in being discharged from our practice.

If you are experiencing financial difficulty, please let us know. We will make payment plan arrangements.

As state above, all copays are due at the time of service. Any patient balances are due with-in thirty days to avoid a late fee of $10.00. Any balances remaining unpaid after ninety days will automatically be sent to collections. In the event this account needs to be placed with an attorney or collection agency because of an unpaid balance, the undersigned agrees and promises to pay a collection fee of $100.00 or 25% of the total balance due, whichever is greater, upon placement with an attorney or collection agency because of unpaid balance remaining on their account.

I have read and understand the financial policy at Randolph Pediatrics.

Parent/Guardian Signature: ____ Date: ____________

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Authorization

Patient Name: ______________________________________ DOB: ________________

Parent/guardian, please initial each statement and sign after you have read and agreed with the following:

________ **AUTHORIZATION** I hereby authorize Dr. Ciufalo to give my child reasonable and proper medical care by today's standards and release medical information for any kind of treatment or payment operations by the office staff of Randolph Pediatrics.

________ **HIPPA** I understand the purpose of the Health Insurance Portability and Accountability Act (HIPPA) that became effective April 14, 2003 and acknowledge that a copy of HIPPA is posted in the office and available to me.

________ **ASSIGNMENT OF INSURANCE BENEFITS** I authorize release of any medical information necessary to process this claim for the patient(s) above and authorize the payment of medical benefits to the named provider for professional services rendered.

________ **OFFICE POLICIES AND PROCEDURES** I am aware of office policies and procedures and fees that are clearly posted at the front desk. I understand that these policies, procedures, and fees may be periodically updated but will be clearly posted. I agree that I am financially responsible for any and all office fees and legal fees incurred on my family's account.

________ **VACCINATIONS** I agree to go to www.cdc.gov or www.immunize.org for vaccination information and understand that I may ask questions prior to vaccination(s) being administered. Copies of Vaccination Information Sheets are available in office.

Parent/Guardian Signature ______________________________ Date ____________

Parent/Guardian Print _________________________________

Credit Card on File Policy

Patients' Names: ____

Thank you for choosing Randolph Pediatrics for your child(ren's) healthcare needs. We are committed to proving you with exceptional care, as well as making our insurance billing process as simple and efficient as possible. Recent shifts in the healthcare industry have resulted in insurance companies increasingly transferring costs to our patients. This is driving us to adopt new financial policies to enable more efficient operational processes.

To streamline our billing and payment system and to provide a seamless, convenient way for patients to pay their bills, Randolph Pediatrics will require all patients to keep an active credit card on file with us. Your credit card information will be kept confidential and secure. We will bill your insurance company first and upon determination of benefits, we will only charge your credit card when they inform us of patient responsibility. Circumstances when your card would be charged include but are not limited to missed or canceled appointments without 24-hour notice, missed co-payments, deductible and co-insurance, any non-covered services and/or denial of services.

If the credit card we have on file changes, please notify us immediately by phone or email. Without an active credit card, a billing fee of $10.00 will be added to any statements we send out to collect balances due.

I authorize Randolph Pediatrics to charge the portion of my bill this is my financial responsibility to the following credit or debit card:

Visa Mastercard

Name on Card: ____

Card Number: ________________________________Expiration Date: _______________

Zip Code: __________ Email Address: ____

I, the undersigned, authorize and request Randolph Pediatrics to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility.
This authorization will remain in effect until I cancel this authorization. To cancel, I must give a 60-day notification to Randolph Pediatrics in writing and the account must be in good standing.

Card Holder Signature ____ Date ________________

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