Patient Registration

Patient Name: _____ **DOB:** _____
Gender Assigned: M / F **Preferred Gender: M / F** **Other:** _____

Parent/Guardian #1: _____DOB: _____ Sex: M / F

Address: _____ Email: _____
(Street) (City/Zip)

Home#: _____ Cell#: _____ Work: _____

Parent/Guardian #2: _____DOB: _____ Sex: M / F

Address: _____ Email: _____
(Street) (City/Zip)

Home#: _____ Cell#: _____ Work: _____

Emergency / Alternative Contact:

Name: _____ **Relationship to Patient:** _____

Email: _____ **Primary Phone #** _____

Please list siblings: **Name** **DOB**

_____ _____
_____ _____
_____ _____

Please list any Allergies, Medications or Medical Conditions:

_____

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

Carrier: _____ **Member ID:** _____

Group #: _____ **Name of Subscriber:** _____

Party responsible for payments:

Whom may we thank for referring to our office? _____

Financial Policy

Patient Name _____**DOB**_____
Patient Name _____**DOB**_____
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 stated above, all copays are due at the time of service. Any patient balances are due within thirty days to avoid a late fee of $10.00. Any balances remaining unpaid after 120 days of first bill date 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:** _____

Randolph Pediatrics

Patient Authorization

Patient Name _____**DOB**_____
Patient Name _____**DOB**_____
Patient Name _____**DOB**_____

_____**AUTHORIZATION:** I hereby authorize Dr. Ciufalo to give me 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.

_____**HIPAA:** I understand the purpose of the Health Insurance Portability and Accountability Act (HIPPA) which protects the privacy and security of patient health information. Please refer to Health and Human Services website - HHS.gov/HIPPA - for more information.

_____**ASSIGNMENT OF INSURANCE BENEFITS:** I authorize release of any medical information necessary to process claims 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, procedures and fees that are available to me. I understand that these policies, procedures, and fees may be periodically updated but will be clearly communicated. I agree that I am financially responsible for all office fees and legal fees incurred on my family's account.

_____**VACCINATIONS**: I am aware of the office policy regarding vaccinations. We do not delay or separate vaccines and follow the recommendations of the American Academy of Pediatrics immunization guidelines and Center for Disease Control recommendations. We strive to maintain the best health and wellness for all our patients and encourage parent/ guardians to ask questions prior to vaccination(s) being administered. Additional vaccination information can be found on the AAP and CDC websites, as well as Immunize.org.

_____**BILLING POLICY:** I am aware of the office billing policies that are available to me. We ask that all families and our patients, 18 and over have a credit card on file (give to front desk or fill out form) ***Credit cards kept on file will be automatically charged for any co-pay, co-insurance, or deductible balances of $150.00 and under.***

Patient/Guardian Signature _____ **Date** _____

Patient/Guardian Print _____ **Date** _____

• 711 Route 10 East • Randolph • NJ • 07869 • 973-328-9200

Credit Card Authorization

Thank you for choosing Randolph Pediatrics for your child(ren's) healthcare needs.

We are committed to providing you with exceptional care, as well as making our billing process as efficient as possible. Randolph Pediatrics requests that all patients keep an active credit card on file. Your card information will be kept confidential and secure.

- Complete the credit card authorization below and return form to the office via patient portal or in person
- Please indicate if this is an HSA account card.
- Balances under $150 will automatically be charged to the credit card on file.
- For balances over $150.00, please indicate below the max allowed to charge.

Name of Patient(s): _____

Visa or Mastercard

Name on Card: _____

Credit Card # to be kept on file _____Expiration Date: _____

MAX ALLOWED OVER $150.00 $_____

HSA CARD? : YES___ NO___

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 mut be in good standing.

Card Holder's Signature _____Date_____

Your insurance will be billed for all visits, and upon determination of benefits, all patient responsibilities will be subject to billing. All co-pays and outstanding balances require payment at the time of service. Overdue balances requiring a second mailed statement will incur a $5.00 administrative fee. Missed or canceled appointments, without 24-hour notice, will be subject to a fee of $50.00.

*Billing Policies are subject to change.

Billing Policies

Thank you for choosing Randolph Pediatrics for your child(ren's) healthcare needs.

We are committed to providing you with exceptional care, as well as making our insurance billing process as efficient as possible. Your insurance will be billed first for all visits, and upon determination of benefits any patient responsibilities will be subject to billing. Additionally, any missed or cancelled appointments (without 24-hour notice) will be subject to a fee of $50.00. Randolph Pediatrics urges all patients to keep an active credit card on file with us, your card information will be kept confidential and secure.

BILLING POLICIES FOR RANDOLPH PEDIATRICS

- Balances requiring a second mailed statement will incur a $5.00 administration fee.
- Credit cards kept on file will automatically be charged for balances of $150.00 and under.
- Missed or canceled appointments, without 24-hour notice, will be subject to a fee of $50.00.
- If you carry a family balance at the time of an office visit, the balance must be paid that day.

CREDIT CARD ON FILE POLICIES

- Please complete the authorization form if you wish to keep a credit card on file.
- Return the form to the office.
- Please indicate on the form if this is an HSA account card.
- Credit cards kept on file will be automatically charged for any co-pay, co-insurance, or deductible balances of $150.00 and under.
- You can authorize use of the credit card on file for balances above $150.00 by indicating the max amount allowed (i.e., $200.00). Otherwise please call the office to authorize payment.

I UNDERSTAND AND AGREE WITH THE STATEMENTS ABOVE AND ACKNOWLEDGE THAT I HAVE RECEIVED ACCESS COPY OF BILLING POLICY

Parent/Guardian Signature: _____ **Date:** _____

Patient Names: _____