MOUNTAIN VIEW MEDICAL GROUP 2010

PEDIATRIC REGISTRATION (under age 18)

Today's Date:____________________

PLEASE DO NOT ABBREVIATE ANY INFORMATION

Patient Information
DOB _____________ SEX: M F
First Name:_______________ MI: ___ Last Name: ____________________
Marital Status: CHILD
Address: ____
SSN: ________________________
City: ____
State:_____ ZIP:_____________
Home Phone: ___________________ Cell Phone: ________________
Primary Care Physician: ________________________________

MOTHER
DOB _____________ SEX: F
First Name:_______________ MI: ___ Last Name: ____________________
Marital Status: MAR'D SING DIV OTH
Address: ____
SSN: ________________________
City: ____
State:_____ ZIP:_____________
Home Phone: ___________________ Work Phone: ____________________
Cell Phone: _________________
Employer Name (no abbreviations please): _____________________________________

FATHER
DOB _____________ SEX: M
First Name:_______________ MI: ___ Last Name: ____________________
Marital Status: MAR'D SING DIV OTH
Address: ____
SSN: ________________________
City: ____
State:_____ ZIP:_____________
Home Phone: ___________________ Work Phone: ____________________
Cell Phone: _________________
Employer Name (no abbreviations please): _____________________________________

OTHER Relationship to Patient: _____________________________________
DOB _____________ SEX: M F
First Name:_______________ MI: ___ Last Name: ____________________
Marital Status: MAR'D SING DIV OTH
Address: ____
SSN: ________________________
City: ____
State:_____ ZIP:_____________
Home Phone: ___________________ Work Phone: ____________________
Cell Phone: _________________
Employer Name (no abbreviations please): _____________________________________

Insurance Information **Who carries this insurance (circle one)? MOTHER FATHER OTHER**
Insurance Name: ____
Ins ID# (Policy #) ____________________________________ Group # ____________________________________
IS YOUR CHILD COVERED BY MEDICAID? YES NO IF YES, YOUR CHILD'S MEDICAID #: _____________
IS YOUR CHILD COVERED BY CHP+? YES NO IF YES, YOUR CHILD'S CHP+ # _______________

Emergency Contact
Name: ____
Phone: ________________________________ Relationship to Patient: ______________________________

UPDATES: I verify that the information on this form is current and unchanged.
DATE/INITIALS:

__________ __________ __________ __________ __________ __________ __________ __________

__________ __________ __________ __________ __________ __________ __________ __________

__________ __________ __________ __________ __________ __________ __________ __________

Guarantor's Billing Agreement

1) I understand that if the insurance claim is denied due to incorrect information that I have provided, I will be billed, and payment in full will be due immediately.
2) I hereby request and authorize Mountain View Medical Group physicians & personnel to deliver medical care to the patient.
3) I verify that I have designated a Mountain View Medical Group physician within this office as my primary care physician with my insurance company. I understand that if the insurance company denies paying my claims because one of these doctors WAS NOT the designated PCP in effect at the time of the visit, that I am responsible for paying in full for all services provided.
4) If Mountain View Medical Group is contracted with my insurance company, I authorize assignment of payment directly to the doctor for services provided me. I understand that Mountain View Medical Group will file the claim with my insurance company and that I am responsible for following up with my insurance company to insure my claim is paid within 60 days of the date of service.
5) I understand that under the terms of the contract of the insurance company, co-payments must be paid at every visit.
6) If I have insurance that Mountain View Medical Group is not contracted with, I agree to pay the bill in full at the time services are provided. I understand that Mountain View Medical Group will file a claim with my primary insurance company (except Tricare) as a courtesy, but that it is my responsibility to follow up with my insurance company to insure personal reimbursement by them.
7) I understand that if I have no insurance coverage, I agree to pay the balance in full at the time services are provided.
8) I understand that medical records are the property of the physicians of Mountain View Medical Group; however, I am entitled to copies, with sufficient advanced notice, upon my written request. I understand that there may be a charge for these copies.
9) I hereby authorize the release of my medical information to the insurance company concerning any illness and treatment.
10) I acknowledge that I can obtain a copy of the Mountain View Medical Group's Privacy Rights / HIPAA Information from the front desk upon my request.
11) I understand that a $35.00 fee may be charged for all appointments missed or not canceled at least 24-hours in advance.
12) I understand that if my account becomes past due, Mountain View Medical Group will take the necessary steps to collect this debt, which will also include all associated collection fees, attorney/legal fees, and court costs.
13) I understand that I am responsible for knowing the benefits of the specific insurance plan(s) I have purchased, and that MVMG is not responsible for interpreting these benefits, or for how my insurance company(ies) process the claims. I further understand that MVMG cannot serve as an intermediary between my insurance company and myself in claims processing or claims disputes; that I must personally resolve these matters with my insurance company.

Guarantor Signature ____________________________ Date ________________

Communication Consent:

A. I DO CONSENT TO LEAVE DETAILED MESSAGES AND/OR DISCUSSION:

I give Mountain View Medical Group, P.C., and their staff permission to leave detailed phone messages on, or to discuss my child's medical care and/or my billing account with, the following: (please initial each one you consent to). This consent will remain in effect until rescinded in writing.

My home phone voice mail # ___________________________ Medical Care ______ Billing Account ______
My cell phone voice mail # _____________________________ Medical Care ______ Billing Account ______
My work phone voice mail # ___________________________ Medical Care ______ Billing Account ______
My spouse (name)___________________________________ Medical Care ______ Billing Account ______
Other (name)____________________ phone # ____________ Medical Care ______ Billing Account ______

Signature: ____ Date: ______________

B. I DO NOT CONSENT TO LEAVE DETAILED MESSAGES:

I wish to be contacted personally, and I do not authorize MVMG to leave detailed messages or conduct discussions regarding my child's medical care and/or billing account with anyone other than myself.

Signature: ____ Date: ____________________

C. REVOCATION OF PRIOR CONSENT:

I wish to rescind the above authorizations.

Signature: ____ Date: ____________________