C & C Medical Associates, PLLC. PEDIATRIC CLINIC
PATIENT REGISTRATION
Please Print

PATIENT NAME: _____
Last First I.

Birth Date: _____ Male ____ Female _____ SSN_____
Month/Day/Year

Patient lives with: *(CIRCLE ONE)* Mother Father Both Parents Guardian Foster Other: _____

Parents Marital Status: *(CIRCLE ONE)* Single Married Widowed Divorced Separated

Fathers Information:
Name: _____ Date of Birth: _____ SS#: _____
Last First I. Month/Day/Year
Mailing Address: _____
Address City/State Zip
Physical Address: _____

Phone #: Home: (____)_____ Cell/Pager: (___)_____

Father Work: (____)_____Ext: ____ Co. Name: _____ Position: _____

Mothers Information:
Name: _____ Date of Birth: _____ SS#: _____
Last First I. Month/Day/Year
Mailing Address: _____
Address City/State Zip
Physical Address: _____

Phone#: Home: (___) _____ Cell/Pager: (____) _____

Mother Work (____)_____ Ext: ____ Co. Name: _____ Position: _____

Other Guardian Information: Relationship: _____
Name: _____ Date of Birth: _____ SS#: _____
Last First I. Month/Day/Year
Mailing Address:_____
Address City/State Zip
Physical Address:_____

Phone#: Home: (___) _____ Cell/Pager: (___)_____

Work (___) _____ Ext: ____ Co. Name: _____ Position: _____

INSURANCE INFORMATION: *Please provide a copy of your current Insurance Card(s)*

Primary Insurance: _____ ID#_____

Group # _____ Subscriber Name: _____

Date of Birth: _____ Relationship to child: _____
Month/Day/Year
Employer: _____ Phone#: _____ EXT: ____

Secondary Insurance: _____ ID# _____

Group# _____ Subscriber Name: _____

Date of Birth: _____ Relationship to child: _____
Month/Day/Year
Employer: _____ Phone#: _____EXT: ____

Others who are authorized to seek care for your child/ren:_____

Friend or Relative not living with you to contact in case of emergency:

Name: _____ Phone#: (___)_____ Relationship:_____

Other Children you are financially responsible for seen in our Clinic: _____

FINANCIAL POLICY

PAYMENTS EXPECTED TIME OF SERVICE:

Payment is required at time services are rendered unless other arrangements have been made in advance. This includes applicable coinsurance and copays for participating insurance companies. The Pediatric Clinic accepts cash, personal checks, VISA, and MasterCard. There is a $40.00 service charge for returned checks.

Accounts with outstanding balances that are 60 days overdue must contact our billing department to make arrangements for payment prior to scheduling appointments. As a courtesy, budget payment arrangements can be made until the balance is paid in full. Budget payments are due each month. Missed payments may result in your account being assigned to a credit reporting collection service.

Accounts with outstanding balances that are over 90 days will be assessed an administrative fee of $10.00 per month. This fee helps cover our costs related to making phone calls, sending letters and statements that are necessary to collect outstanding balances.

INSURANCE:

We bill participating insurance companies as a courtesy to you. You are expected to pay your co-pay at the time of service. All missed co-pays will be assessed a $6.00 administrative fee. If we have not received payment from your insurance within 45 days due to lack of response from the insured for requested information, you will be expected to pay the balance in full. We will refund any overpaid amount should your insurance reconsider your claim upon receipt of your information.

LATE OR MISSED APPOINTMENTS/LATE CANCELLATIONS:

Broken appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. Cancellations are requested 24 hours prior to the appointment. We reserve the right to charge $20.00 for missed or late-canceled appointments. Excessive abuse of scheduled appointments may result in discharge from the practice. More than 3 visits within the prior 12 month period are considered excessive. We ask that you arrive on time for all appointments. Late arrivals are disruptive to the flow of the office. If you arrive more that 15 minutes late for your appointment, you may be asked to reschedule your appointment.

MINORS RIGHT TO CONSENT TO HEALTH CARE WITHOUT A PARENT OR GUARDIAN CONSENT

Under Washington State law, minors have the right to consent to certain health care without a parent or guardian's consent. For further information, please ask our front desk for our detailed handout that provides more information.

Once a patient becomes pregnant, their care will be transferred to an appropriate provider who cares for pregnant patients.

ASSIGNMENT OF BENEFITS AND RESPONSIBILITY:

I have read and understand the Pediatric Clinic Financial Policy. I agree to assign insurance benefits to the Pediatric Clinic whenever necessary. I also agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for costs of collections, including attorney fees.

PRINT NAME:_____ **DATE:** _____

SIGNATURE OF PARENT OR GUARDIAN: _____

RELATIONSHIP TO PATIENT: _____