Kaplan Barron Pediatric Group

Patient Registration (Patients 18 Years & Older)

Patient Information

- **Patient Name:** _____**Date of Birth:** _____
- **Gender:** ☐ Male ☐ Female ☐ Other_____
- **Address:** _____
- **Preferred Contact Number:** _____

☐ May we leave a message? ☐ Yes ☐ No

- **Email Address:** _____
- **Send Patient Portal Invite?** ☐ Yes ☐ No

Health Insurance Information

Primary Health Insurance

- **Insurance Company:** _____**Effective Date:** _____
- **Policy Holder Name:** _____
- **Date of Birth:** _____
- **Relationship to Policy Holder:** ☐ Self ☐ Parent ☐ Other: _____

Secondary Health Insurance (if applicable)

- **Insurance Company:** _____**Effective Date:** _____
- **Policy Holder Name:** _____
- **Date of Birth:** _____
- **Relationship to Policy Holder:** ☐ Self ☐ Parent ☐ Other: _____

Emergency Contact Information

Contact #1

- **Name:** _____
- **Relationship:** _____
- **Phone Number:** _____
- **Access to Medical Records:**

☐ Full Access ☐ Billing Info Only ☐ No Access

Contact #2

- **Name:** _____
- **Relationship:** _____
- **Phone Number:** _____
- **Access to Medical Records:**

☐ Full Access ☐ Billing Info Only ☐ No Access

Policy for Missed Appointments

I have been informed by Kaplan Barron Pediatric Group (KBPG) that the office requires **24-hour notice** for all appointment cancellations. I understand that I will be charged **$25 (sick visit) to $40 (well visit)** per missed appointment depending on the appointment type. I understand that **three missed appointments will result in discharge from the practice**.

- **Patient Signature: _____Date: _____**

Consent to Use & Disclose Health Information (HIPAA)

I understand that as part of my health care, KBPG originates and maintains paper and/or electronic health records. I acknowledge that I have been provided access to the **Notice of Privacy Practices** and understand my rights under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Authorization Choice (Initial One Option)

☐ **Full Access Authorization**

I allow the following individuals complete access to my medical records:

- Name: _____ Relationship: _____
- Name: _____ Relationship: _____

OR

☐ **Limited Access Authorization**
I allow the following individuals access only to diagnosis and treatment information related to charges incurred:

- Name: _____ Relationship: _____
- Name: _____ Relationship: _____

I understand that my protected health information may be disclosed for treatment, payment, and health care operations, including via fax, as permitted by federal law.

- **Patient Name:** _____
- **Date of Birth:** _____
- **Patient Signature:** _____
- **Date:** _____

Declination to Use or Disclose Information

I do **not** wish for any of my medical or financial information to be discussed with or released to anyone other than myself. I understand that I will be the **Responsible Party** on my account and financially responsible for all charges. I also understand that no one will be allowed to schedule appointments or receive medical advice on my behalf.

Financial Guarantee

I guarantee personal payment of all charges incurred for services rendered by KBPG. In the event of default, I agree to pay all costs associated with collection proceedings, including a **collection fee of 30% of the balance plus postage costs**.

- **Patient Name:** _____
- **Date of Birth:** _____
- **Patient Signature:** _____
- **Date:** _____