Associated Pediatric Partner S.C **PLEASE PRINT CLEARLY FAX TO 847-520-6091**

Patient Name: _____ M / F D.O.B._____
Last First Middle

Patient Name #2: _____ M / F D.O.B._____

Patient Name #3: _____ M / F D.O.B._____

Patient Name #4: _____ M / F D.O.B._____

Child/Children's Address

Street Address: _____

City, State, Zip: _____

Your Preferred Contact Number: _____ **Email:** _____

Parent/Guardian #1_____ D.O.B._____
Last First Middle

Relationship to Patient: _____

Address (if different than above): _____

City/State/Zip:_____

Home Phone:_____ Cell Phone: _____

Email:_____ Employer:_____

Are you the primary insurance carrier? (circle one) Yes No

Parent/Guardian #2: _____ D.O.B._____
Last First Middle

Relationship to Patient: _____

Address (if different than above): _____

City/State/Zip:_____

Home Phone:_____ Cell Phone: _____

Email:_____ Employer:_____

Are you the primary insurance carrier? (circle one) Yes No

Marital Status of Parent/Guardian (circle one): Married Divorced Separated Widowed Single

Child Resides With: _____

Party Responsible For Payment of Medical Services_____

Emergency Contact Information (Not Living with Patient)

Name: _____ Phone Number: _____

Address: _____ City/State/Zip:_____

Relationship to Patient: _____

AUTHORIZATION FOR TREATMENT AND FINANCIAL AGREEMENT

I hereby assign my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for all non-covered services, copays, deductibles and/or coinsurance. I authorize and give consent for my provider to bill me directly for recommended services performed that are not covered under the terms of my health plan. It is agreed that payment for services will not be delayed or withheld because of any insurance coverage of the pendency of claims thereon, and that all proceeds of the insurance for services rendered in the practice are assigned to ASSOCIATED PEDIATRIC PARTNERS SC but without the clinic's assuming sole responsibility for the collection thereof. I authorize the physician to release any medical information required to process this claim and I authorize access to my medication history. I authorize group, its physicians, practitioners, independent contractors, business associates, agents and/or affiliates to contact me using email, and autodialed calls, texts, and artificial voices or prerecorded voices at the telephone numbers provided with regard to billing, collections, and other account and patient activities. I understand that I am not required to provide this call consent, and I may revoke it at any time. A $50.00 fee for no shows may apply.

Signature: _____ Date: _____ 07/19

Patient Name: _____
Last First Middle

Patient Name #2: _____

Patient Name #3: _____

Patient Name #4: _____

PRIMARY INSURANCE INFORMATION

Policy Holder Information

Policy Holder Name: _____
Last First Middle

Street: _____

City: _____State: _____ Zip: _____

Policy holder date of birth:_____

Insurance Plan Name:_____

Policy ID No: _____

Policy Group: _____

Patient's relationship to policy holder: _____

This registration form may also be emailed to frontdesk@associatedpediatricpartners.com Please remember that email isn't 100% secure, and should not be used for Protected Health Information.

Vaccination Policy

As medical professionals, we feel very strongly that vaccinating your child according to the schedule recommended by the CDC and American Academy of Pediatrics is absolutely necessary to protect all children and young adults. When you do not vaccinate, you take a significant risk with your child's heath and the health of others around them. At Associated Pediatric Partners, we firmly believe in the effectiveness of vaccines to prevent serious illness and save lives, and we firmly believe in the safety of vaccines. Delaying or spreading out vaccinations goes against expert recommendations, and can put your child at risk of serious illness or even death.

If, without a valid medical contraindication, you feel that you cannot stay within the recommended time frame for vaccination based on the schedules published by the CDC and American Academy of Pediatrics, we will ask that you find another healthcare provider.

By signing below, I have read and understand the above Associated Pediatric Partners Policy.

Signature of Parent/Guardian: _____

Date: _____