PATIENT REGISTRATION

Last Name: ______________________ First Name: _______________________ MI: _____

Preferred Name/Nickname: ___________________ D.O.B.: ________________ Sex: _______

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(Home Street Address) (Apt) (City) (State & Zip)

Home Phone: _________________Cell Phone: _______________ Email Address: ____________________________

Parent/Contact 1: Name: ___________________________ Relation to Patient: ________________

Date of Birth: _____________ Lives with patient? ☐ Yes ☐ No, _____________________________

Work Phone: __________________________ Cell Phone: __________________________

Home Email: __________________________________ Work Email: _____________________________

Parent/Contact 2: Name: __________________________________ Relation to Patient: ________________

Date of Birth: _____________ Lives with patient? ☐ Yes ☐ No, _____________________________

Work Phone: __________________________ Cell Phone: __________________________

Home Email: __________________________________ Work Email: _____________________________

Primary Policy: Policy Holder's Name: ______________________ Policy Holder's Birth Date: ______________

Insurance Carrier: _____________ Insurance Address: ____

Member ID # ___________________________ Category/Group # ______________________________

Co-Pay Amount $: ______________________ Policy Effective Date: _____________________

Emergency Contact:

Name & Relationship: _______________________/____________________ Phone: ______________________

Pharmacy Information:

Name: _____________________ Address: _________________________________ Phone: ______________________

This information that I have given is correct and true to the best of my knowledge. Understand that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status.

____ ________________________________

Signature of Patient or Parent/Legal Representative **Date**

OFFICE POLICIES

FINANCIAL POLICY-ALL PAYMENT IS EXPECTED AT THE TIME OF SERVICE

- Payment is required at the time services are rendered unless other arrangements have been made in advance. This includes applicable coinsurance and co-payments for participating insurance companies. MVP accepts cash and credit card.
- There may be services rendered that we feel provide the highest quality of care for your child but may not be covered by insurance. These include vision screening, hearing screening, developmental screenings and other in-office tests like rapid flu. If your insurance does not cover these services, you will be responsible for their cost.

AUTHORIZATION TO RELEASE INFORMATION

- I authorize MVP to release any information necessary to insurance carriers regarding my child's illness and treatments in order to process insurance claims.

MISSED APPOINTMENTS/CANCELLATIONS/LATE POLICY

- We have a strict 20 minute late policy. If you are more than 20 minutes late for your appointment, you will have to be rescheduled.
- Missed 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.
- In the event that you do not cancel in advance or do not show up for an appointment, there will be a $25 charge to you that is not covered by insurance.

FORMS/FEES

- There is a $10 administrative fee for all school, camp and sports forms to be completed within 7 business days.
- There is a $25 administrative fee for all expedited forms. These forms will be completed within 48 hours.
- Most insurance companies cover Telemedicine and Phone visits that last more than 10 minutes. There may be a copayment that you are responsible for paying.

I have read and understand this office policy and agree to comply and accept the responsibility for any payment that becomes due as previously outlined.

Patient Name ________________________

Responsible Party Member's Name __________________________

Relationship _______________ Signature ____________________ Date ______________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

We are required by State and Federal laws, including the HIPAA rules, to safeguard general and health-related information about you. We have a Notice of Privacy Practices that explains how your protected health information is handled and how we may use and/or disclose your protected health information. The Notice of Privacy Practices is provided to patients (and/or their authorized representatives) when they first become our patient.

We are asking you to sign this form to show that we offered you a copy of our Notice of Privacy Practices. Copies are available on our website and personal copies can be requested from our staff. By signing below you are only acknowledging that you were offered or received a copy of the **Notice of Privacy Practices**. You may refuse to sign this acknowledgment if you wish. You are not making any statement about the content of the Notice of Privacy Practices or about your agreement or disagreement with any portion of it.

Acknowledgment
I acknowledge that Manhattan Valley Pediatrics has offered or provided me with a copy of its Notice of Privacy Practices, which describes how medical information about me may be used and/or disclosed and how I can access this information.

I understand that if I have questions or complaints I may contact: Manhattan Valley Pediatrics at 917-921-6219. I also understand that I am entitled to receive updates upon request if MVP amends or changes its Notice of Privacy Practices in a material way.

____________________________________ ____________________
Signature of patient or patient's representative — Date

____________________________________ ____________________
Printed name of patient/patient's representative — Relationship to patient

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For OFFICE USE ONLY
I made a good faith effort to obtain a written acknowledgment of receipt of the Notice of Privacy Practices from the above-named patient, but was unable to because:

☐ Patient declined to sign this Written Acknowledgment.
☐ Other (Specify):

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____________________________________ ____________________
Name and Title of Employee — Date