DARIEN PEDIATRIC ASSOCIATES, LLC

Family Registration Form

Parent #1 Name_____
Address_____

Birth Date_____
Home Phone_____
Cell Phone_____
Email_____
Occupation_____
Married Divorced Living Together Widowed
Custodial Parent (please circle)

Parent #2 Name_____
Address_____

Birth Date_____
Home Phone_____
Cell Phone_____
Email_____
Occupation_____
Married Divorced Living Together Widowed
Custodial Parent (please circle)

LIST ALL CHILDREN PATIENTS

Last Name	First Name	Sex	Date of Birth	Cell Phone	Insurance ID

EMERGENCY CONTACT:_____ PHONE:_____ RELATIONSHIP:_____

PHARMACY USED:_____ LOCATION:_____

PRIMARY INSURANCE:_____ POLICY ID:_____ GROUP #_____

NAME OF SUBSCRIBER:_____ EFFECTIVE DATE:_____

Authorization for Treatment and Assignment of Benefits: I authorize Darien Pediatrics to treat my children & to release medical information necessary for the completion of insurance, school & camp forms. I authorize payment directly to Darien Pediatrics for any & all medical/surgical benefits otherwise payable to me under the terms of my insurance. In addition, I will reimburse Darien Pediatrics for any payments my insurance company may have sent to me in error**. I understand that I am financially responsible for all co-payments and any surcharges not covered under my insurance benefits.** It is my sole responsibility to advise Darien Pediatrics of any changes to my insurance coverage**. PAYMENT OF CO-PAYS AND DEDUCTIBLES ARE DUE AT THE TIME OF SERVICE. THERE WILL BE A $10 SURCHARGE APPLIED TO ACCOUNTS FOR NON-PAYMENT OF THESE FEES AT THE TIME OF SERVICE.** Our office requires 24 hours' notice of appointment cancellations. Failure to provide this notice will incur a $50 cancellation fee. It is our policy that the parent bringing the child to the office is responsible for payment of medical care. You can review our complete Financial Policy on our website. We are required by State & Federal laws, including the HIPPA Rules to safeguard general & health related information about our patients. I understand these Hippa Laws also apply to telemedicine.

I acknowledge that Darien Pediatrics Associates, LLC has offered or provided me with Notice of Privacy Practices. The undersigned understands that they are financially responsible for the account of the above children.

PRINT NAME_____ SIGNATURE_____ DATE_____