Springdale-Mason Pediatrics
Patient Registration Form

Patient Information:

Children's Names	Birthdate	Sex	If patient is 18 or over, we need his/her phone number

Preferred provider (in our practice): ______________________________

Preferred Pharmacy: ______________________ Location: ______________________

Emergency Contact: ______________________ Phone Number: ______________________

Relationship to Patient: ______________________

Father's Information

Name: ______________________ Birthdate: ______________________

Address: ______________________
(Street) (City, State, Zip, County)

Telephone: Home: ______________ Cell: ______________ Work: ______________

Email Address: ______________________ Lives with patient? Yes / No

Biological Parent? Yes / No If no, relationship to patient:______________________

Mother's Information

Name: ______________________ Birthdate: ______________________

Address: ______________________
(Street) (City, State, Zip, County)

Telephone: Home: ______________ Cell: ______________ Work: ______________

Email Address: ______________________ Lives with patient? Yes / No

Biological Parent? Yes / No If no, relationship to patient:______________________

Additional Contact Questions

Who should receive billing statements? ______________________

May all contacts have access to the patient's records electronically? Yes / No / ______________________

Male Step-Parent (if applicable) ____ Phone Number:_______________________

Legal Male Guardian (if applicable) ____ Phone Number: ______________________

Relationship to Patient: ____

Female Step-Parent (if applicable) ____ Phone Number: ______________________

Legal Female Guardian (if applicable) ____ Phone Number: ______________________

Relationship to Patient: ____

Insurance Information

Primary Insurance Coverage: ____
(Company name) (Claims mailing address)

Subscriber Name: ____ Birthdate:_____________________________

SS#: ______-_____-_______ Policy #: ____ Group #: ________________________

Employer: ____ Effective date of coverage: ______________________

Secondary Insurance Coverage: ____
(Company name) (Claims mailing address)

Subscriber Name: ____ Birthdate:___________________

SS#: ______-_____-_______ Policy #: ____ Group #: ____________________

Employer: ____ Effective date of coverage: ______________________

I hereby authorize Springdale-Mason Pediatrics (SMP) to submit a claim to my insurance carrier or its intermediaries for all covered services rendered by SMP healthcare providers and hereby direct my insurance carrier or its intermediaries to issue payment directly to Springdale-Mason Pediatrics on behalf of such rendered services.

I understand that I am financially responsible to the office for any balance not covered by my insurance carrier.

Signature: ____ Date: ________________________

In the event that the parent(s) or legal guardian(s) are unable to accompany the child during an office visit, I hereby authorize the physicians of Springdale-Mason Pediatrics to evaluate and treat any and all conditions that require attention.

Signature: ____ Date: ________________________

I give Springdale-Mason Pediatrics permission to leave information that includes patient name and limited medical information on my voice mail or answering machine.

Signature: ____ Date: ________________________

The Practice's Notice of Privacy Practices was made available to me and I understand that my protected health information may be used by the Practice as described in the notice. I am also aware that I may I may review the Notice of Privacy Practices at any time.

Signature: ____ Date: ________________________

Child's Name:____ Primary Language:____________________________

Ethnicity: Unknown / Hispanic or Latino / Non-Hispanic or Non-Latino / Decline to specify

Race: American Indian or Alaskan Native / Asian / Black or African American / Hawaiian / White / Decline to specify

Child's Name:____ Primary Language:____________________________

Ethnicity: Unknown / Hispanic or Latino / Non-Hispanic or Non-Latino / Decline to specify

Race: American Indian or Alaskan Native / Asian / Black or African American / Hawaiian / White / Decline to specify

Child's Name:____ Primary Language:____________________________

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Child's Name:____ Primary Language:____________________________

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Race: American Indian or Alaskan Native / Asian / Black or African American / Hawaiian / White / Decline to specify

How would you ideally prefer to be contacted regarding (circle one including which parent if applicable):

Medical Issues: Home Phone / Work Phone (Mom or Dad) / Cell Phone (Mom or Dad) / Email Address (Mom or Dad)

Appointment Reminders: Home Phone / Cell Phone (Mom or Dad) / Email Address (Mom or Dad)

Recall Notices: Home Address / Home Phone / Work Phone (Mom or Dad) / Cell Phone (Mom or Dad) / Email (Mom or Dad)

Billing Statements: Home Address / Email (Mom or Dad)

General Practice Notices: Home Address / Home Phone / Cell Phone (Mom or Dad) / Email Address (Mom or Dad)

Patient Portal Notifications: Cell Phone (Mom or Dad) / Email Address (Mom or Dad)

Springdale-Mason Pediatric Associates, Inc.
Patient Financial Policy

Accepted form of payment: Cash, Check, Visa, Master Card, Discover, American Express, or money order.

Insurance: A current insurance card must be presented at every appointment. We will file for all insurance companies we are contracted with (you must verify with your plan if we are covered). We only accept contractual write off if we are contracted with the patients' specific insurance company. Remember that your insurance policy is a contract between you and your insurance company. **The patient is responsible for any non-covered charges and should always be familiar with their insurance benefits.**

Assignment of Benefits: I hereby authorize my insurance benefits be paid directly to Springdale Mason Pediatric Associates, Inc., realizing I am responsible to pay all non-covered services and I hereby authorize the release of pertinent medical information to insurance carriers and/or specialists referred by the physicians.

Copayments/Coinsurance/Deductibles: Copayments are due at the time of service. **This is an agreement between you and your insurance company.** If you are aware of any coinsurance or deductible due that should be paid as well.

Office Procedures, Tests and Labs: Our providers feel that these additional tests are very important to your child's health and follow the AAP recommendations to perform these tests. Unfortunately, not all services provided by our office are covered by every plan. Any service determined to not be covered by your plan will be your responsibility. Furthermore, if we must send a lab out of the office for testing, it is your responsibility to inform us of your insurance company's preferred lab, if this information is not provided we will send it out to the lab we see fit for the testing.

After Hours: If your child is seen after regular business hours (regular business hours are Monday through Friday 8 am to 5 pm), a $20 fee will be charged in addition to any treatment on that visit.

Responsible Party: Both parents are considered financially responsible unless there is a legal document stating otherwise. Statements can only be sent to one parent. All copays are due at the time of service by the person bringing the child into the office. Statements are sent only to the responsible party.

Self-Pay (no insurance): Payment is expected at the time of service for all charges.

Billing: You will only receive a bill from us if there is a balance due on your account. If you don't understand or feel you don't owe the balance, please contact the Billing Office immediately to get the situation taken care of. Balances are expected to be paid in full upon receipt of a statement. If a situation arises where this is not possible, please contact our Billing Office. We might consider dismissing your family from our practice if there are continuing unpaid balances on your account. The Billing Office phone number is (513)-771-5956. They can be reached Monday through Thursday 9:00 am to 1:00 pm and 2:00 pm to 4:00 pm. They also have voicemail available and will return your call as soon as they can.

Workers Compensation/Auto accidents: We do not bill insurance companies for these visits. When seen, we require payment in full at the time of service. It is your responsibility to submit your bill to the appropriate insurance agency for reimbursement.

Returned Check: If a check is returned to us unpaid from your bank there is a $30 fee that will be added to your account. We expect the returned check amount plus the fee to be paid to Springdale-Mason Pediatrics within 10 working days of notification.

No Show Appointments: We require 24-hour notice when cancelling an appointment. We will charge $25 per each 15-minutes allotted for the scheduled appointment for all broken appointments and no shows. On average, you will be charged $50 for a missed checkup and $25 for a missed sick visit for each child scheduled. We also will dismiss a family from our practice for frequent broken appointments and no shows.

I have read and understand Springdale Mason Pediatrics Associates entire financial policy as stated above and I agree to its terms. I also agree that such terms may be amended by Springdale Mason Pediatric Associates at any time.

Signature of Responsible Party | Printed Name of Responsible Party | Date

SPRINGDALE-MASON PEDIATRICS

Child's Name____ Date of Birth________________

Past Medical History

Pregnancy/Neonatal Period

Full Term: ◻ Yes ◻ No

Born at _________ weeks

Birth Weight: ____________

Delivery: ◻ Vaginal ◻ C-Section

Reason for C-Section: ____

Any Birth Complications: ____

Infancy/Childhood/Adolescence

Has your child ever been treated for or diagnosed with (explain):

◻ Asthma or Reactive Airway Disease ____

◻ Wheezing or bronchiolitis ______________________

◻ Pneumonia ___________________________________

◻ Seasonal Allergies ______________________

◻ Food Allergies ___________________________________

◻ Eczema ______________________________

◻ Recurrent Ear Infections ________________________

◻ Urinary tract infections _________________

◻ Genetic Syndrome _____________________________

◻ Seizures ______________________________

◻ Anemia ______________________________________

◻ Broken Bone __________________________

◻ Learning Disability ______________________________

◻ ADD/ADHD ____________________________

◻ Autism Spectrum Disorder ______________________

◻ Developmental Delay __________________

◻ Depression/Anxiety _____________________________

Other chronic medical conditions: ____

Has your child ever been hospitalized: ◻ Yes ◻ No (explain)

____

Previous Surgeries and dates: ____

____

Allergic to any medications: ◻ Yes ◻ No (explain)

____

Current Medications and dose: ____

____

Please list any specialist your child is currently seeing and reason: ________________________________

____

Social History

Child's parents are: ◻ Married ◻ Unmarried ◻ Divorced ◻ Other

Who lives in the household with child? ◻ Mom ◻ Dad ◻ Siblings (#________) ◻ Grandparents ◻ Other ____________________

Do any household members smoke? ◻ Yes ◻ No

Any Pets in the home? ◻ Yes ◻ No

What kind of pets: ____

Any guns in the home? ◻ Yes ◻ No

Are they locked up? ◻ Yes ◻ No

SPRINGDALE-MASON PEDIATRICS
PATIENT CONSENT AND PHARMACY INFORMATION UPDATE

Child's Name | Date of Birth

____

____

____

____

I give Springdale-Mason Pediatrics permission to search for my child's/children's medication history.

Signature:____ Date:____________________

Please give us your preferred pharmacy information.

Pharmacy Name: __________________________________ Phone Number:____________________

Address: ____

Past Medical History (Please try to be specific with illness)	Mother	Father	Sibling (please name)	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Maternal Aunt/Uncle	Paternal Aunt/Uncle
Nasal Allergies or other allergies									
Asthma/Lung Disease									
Heart Disease									
High Blood Pressure									
High Cholesterol									
Diabetes									
Other endocrine problem (thyroid)									
Cancer (please list type)									
Anemia									
Bleeding Disorder									
Epilepsy or Convulsions									
Developmental Disorders									
Neurological disorder including ADHD/ADD									
Liver disease									
Gastrointestinal disorder									
Kidney Disease									
Bedwetting									
Hearing impairment									
Vision impairment or eye disorder									
Immune problems, recurrent infections or HIV/AIDS									
Alcohol Abuse									
Drug Abuse									
Mental illness									
Tuberculosis									
Additional pertinent condition									