

Kansas City Pediatric Cardiology

PATIENT REGISTRATION FORM

First Name _____	Middle Intl _____	Last Name _____	Nickname _____
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Birth Date: _____ Male _____ Female _____ Primary Care Physician _____
 Race: _____ Hispanic or Latino: Y or N Primary Language: _____
 Primary Phone:() _____ Secondary Phone:() _____
 Address _____
 City _____ State _____ Zip _____

Status of Parents: Married Separated Divorced Widowed Unmarried

Mother or Guardian Information

_____ Primary Phone () _____
 Last Name First Name

RELATIONSHIP TO PATIENT(S): Mother Step-Mother Grandparent Foster Parent Other _____

Email Address: _____ SSN# _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Work Phone: () _____

Father or Guardian Information

_____ Primary Phone () _____
 Last Name First Name

RELATIONSHIP TO PATIENT(S): Father Step-Father Grandparent Foster Parent Other _____

Email Address: _____ SSN# _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Work Phone: () _____

WITH WHOM DOES THE CHILD RESIDE? Father Mother Legal Guardian Step Parent Foster Parent Other _____

If child/children are living with step parent or other relative, please complete the following:
 Name: _____ DOB: _____ Phone#() _____

<p>Primary Health Insurance:</p> <p>1) Company Name: _____</p> <p>Policy ID#: _____</p> <p>Subscriber's Name: _____</p> <p>Subscriber DOB: _____</p> <p>RELATIONSHIP TO PATIENT: <input type="checkbox"/> MOTHER <input type="checkbox"/> FATHER</p> <p><input type="checkbox"/> STEP-PARENT <input type="checkbox"/> OTHER: _____</p>	<p>Secondary Health Insurance:</p> <p>2) Company Name: _____</p> <p>Policy ID#: _____</p> <p>Subscriber's Name: _____</p> <p>Subscriber DOB: _____</p> <p>RELATIONSHIP TO PATIENT: <input type="checkbox"/> MOTHER <input type="checkbox"/> FATHER</p> <p><input type="checkbox"/> STEP-PARENT <input type="checkbox"/> OTHER _____</p>
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I authorize Kansas City Pediatric Cardiology to release any and all medical records, pertaining to my child's health, to my insurance company for any requested additional information. I, _____, hereby acknowledge that Kansas City Pediatric Cardiology Associates has provided me with a copy of its Notice of Privacy Practices that describes how medical information about me/my child may be used and disclosed, and how I can access this information. I also acknowledge that I was provided with Kansas City Pediatric Cardiology Associates financial policy and agree to the policy as stated. I understand that if I have questions or complaints I may contact KCPCA.

Signature _____ Date _____

CONSENT OF TREATMENT

The physicians of Kansas City Pediatric Cardiology have my permission to provide my child/children with any necessary treatment. The following persons have my permission to seek medical attention for my child/children in my absence.

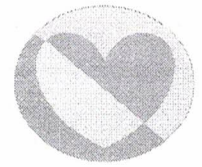
1) _____ (2) _____ (3) _____

Referring Provider: _____

Parent/Legal Guardian Signature _____ Date _____



Kansas City Pediatric Cardiology Associates
Office Financial Policy



We would like to thank you for choosing Kansas City Pediatric Cardiology. As one of our patients, we would like to keep you informed of our current office and financial policies. We require a signature to document that you have read and understand these policies.

Payment

- Payment is expected at the time of service. This is an insurance company rule. This includes co-payments participating insurance companies. Kansas City Pediatric Cardiology, accepts cash, personal checks, most major credit cards. There is a service charge of \$25 for returned checks.
- Patients with an outstanding balance more than 90 days overdue must make arrangements for payment prior to scheduling appointments. Parents are ultimately responsible for any charges or portion thereof for which payment is denied by insurance for whatever reason, except where prohibited by law or prior contractual agreement.

Insurance

- It is the patient's responsibility to provide us with current insurance information and to present an active insurance care at each visit.

Referrals

- If your plan requires, you may need to receive a referral from your primary care physician. It is your responsibility to obtain this referral if it is required by your insurance company.

Canceled Appointments

- If you are unable to keep your scheduled appointment, please call our office 24 hours before your appointment to reschedule. This will allow time to provide that time slot to another patient.
- We reserve the right to charge \$25 for appointments that are not canceled at least 24 hours in advance.

Past Due Accounts

- If this account is not paid when due, and Kansas City Pediatric Cardiology has to retain an attorney or collection agency for collection, I/we agree to pay all late fees, costs of collection including reasonable interest, reasonable attorney's fees (even if suit is filed) and reasonable collection agency fees.

More Information

- Please call our office at (816) 584-0505 if you have a question about your bill. Most problems can be settled quickly and easily, and your call will prevent any misunderstandings.
- If you are having trouble paying you bill, please discuss the situation with us. Satisfactory arrangements can almost always be made.
- Financial considerations should never prevent children from receiving the care they need at the time they need it.

Signature _____ **Date** _____