Acorn Pediatrics of San Antonio
Patient Registration

Patient(s) name(s) (First, middle, last) Date of Birth Lives with Mom Dad Both

_____ _____ ____ ____ ____

_____ _____ ____ ____ ____

_____ _____ ____ ____ ____

Preferred pharmacy- Name _____ Street _____ Phone (_____)_____

Parent 1

Name _____ Responsible party ? _____ yes _____ no

Address _____
(street) (city) (Zip code)

Date of birth _____ Social security number _____ Driver's license # _____

Phone: Home (_____)_____ cell (_____)_____ work (_____)_____

Occupation _____

Email _____ May we email you appointment reminders and statements? ____ yes ____ no

Parent 2

Name _____ Responsible party ? _____ yes _____ no

Address _____
(street) (city) (Zip code)

Date of birth _____ Social security number _____ Driver's license # _____

Phone: Home (_____)_____ cell (_____)_____ work (_____)_____

Occupation _____

Email _____ May we email you appointment reminders and statements? ____ yes ____ no

Emergency contact

Name _____ Phone number (_____)_____ Relationship _____

Primary insurance

Name of insured _____ Patient relationship to insured _____

Insured employer name _____Ins. company name _____ phone (_____)_____

Subscriber ID (policy number) _____ Group ID _____

Secondary insurance

Name of insured _____ Patient relationship to insured _____

Insured employer name _____Ins. company name _____ phone (_____)_____

Subscriber ID (policy number) _____ Group ID _____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge. I authorize release of medical information necessary to process this bill with my insurance company and request payments be made to Acorn Pediatrics of San Antonio. Acorn Pediatrics will make efforts to file claims on my behalf, however I acknowledge that I am ultimately financially responsible for payment whether or not covered by insurance.

Responsible party signature _____ Date _____

Acknowledgement Of Receipt Of Notice Privacy Practices

I have received a copy of this office's Notice of Privacy Practices which explains how my medical information will be used and disclosed. I understand that I am entitled to a copy of this form if requested.

Patient Name_____ DOB _____

Parent Name _____ Signature _____ Date_____

Notice of Office Policies

At Acorn Pediatrics of San Antonio we will make every effort to file insurance claims on your behalf. Copays, deductibles, and coinsurance along with outstanding balances are due at the time of service. Any remaining balance due after your health plan pays is due upon receipt. Account balances over 90 days may be sent to a collection agency.

Your insurance policy is a contract between you and your insurer. Do not assume your policy covers all services at 100%. We can't quote your benefits. Any items deemed "not covered" will be your responsibility. This includes lab work and other outside providers.

We request you please keep us up to date on address and phone numbers so we can better serve you.

We are not party to legal disputes. Financial responsibility for a visit rests with the adult presenting with the patient or the patient if over 18.

A $35 fee will be assessed for all returned checks - that amount may be higher if higher bank fees are incurred.

A $50 no show fee per patient will be charged for physical and ADHD evaluation appointments not cancelled 24 hours prior.

Payments are applied to the oldest charges first, except for insurance payments which are applied to the corresponding date of service. Refunds over $50 will be provided within 30 days of all outstanding claims being satisfied. Credit balances less than that will be processed at the patient's request.

I have read the above and been allowed to ask any questions.

Signature _____ Date _____