Clay City Pediatrics & Primary Care

New Patient Registration

PATIENT INFORMATION

Name: _____ **Date of Birth:** _____

Social Security #:_____ **Gender:** male female

Marital status: single married divorced separated widow

Mailing address: _____City_____State_____Zip_____

Physical Address (if different from mailing)_____City_____State_____Zip_____

Home#:_____**Cell#:**_____**Work#**_____

Preferred Email:_____

Preferred Pharmacy:_____**City, State**_____

RESPONSIBLE PARTY (If filling out form for child)

Name: _____ **Date of Birth:** _____

Relationship to Patient: parent grandparent sibling other:_____

Mailing address: _____City_____State_____Zip_____

Social Security #:_____ **Gender:** male female

Home#:_____**Cell#:**_____**Work#**_____

INSURANCE INFORMATION (if the subscriber is not the patient)

Subscriber name: _____ **Date of Birth:** _____

Mailing address: _____City_____State_____Zip_____

Social Security #:_____ **Relationship to patient:**_____

ID#: _____ **Group #:** _____**Co-pay:** _____

EMERGENCY CONTACT

Name: _____ **Relationship:** _____

Mailing address: _____City_____State_____Zip_____

Home#:_____**Cell#:**_____**Work#**_____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am responsible for any balance. I also authorize Clay City Pediatrics or insurance company to release any information required to process my claims.

_____ _____

Patient or Guardian Signature **Date**

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Clay City Pediatrics & Primary Care

Patient Consent

Thank you for choosing us to assist you with your health care needs. We strive to provide you with the best care possible and, in return, we ask that you assist us not only in monitoring your healthcare, but also by paying for our services in a responsible and timely manner.

The following is a statement of our Privacy and Financial Policy. Please read through this statement and feel free to ask us any questions.

- **Insurance:** Our office accepts assignment of benefits from many insurance companies, HMO, and PPO programs. However, we do not accept all benefit programs. Therefore, please inquire as to whether or not your insurance company, HMO, or PPO is accepted by this office when taking into account what method of payment you will want to use.
- **Payment:** **We require that your co-payment or deductible be made at the time of service.** In the event that we do not accept assignment of benefits from a particular insurance company, HMO or PPO, we require that you pay your bill in full at the time of service. Your bill is your responsibility. If your insurance company or other benefit program doesn't cover the entire bill, it's your responsibility to pay the balance. We expect payment in full within 45 days of being notified of any balance due. Please be aware that some services provided may be non-covered services and are not considered reasonable and necessary under the Medicare Program and/or other insurance companies, HMO, or PPO, or other benefit programs.

We accept cash, personal checks, and credit or debit cards

- **Bad Check Policy:** There will be a $30.00 charge added to fees for any check returned to us unpaid by your bank.
- **Usual and Customary Rates:** We are dedicated to providing the best treatment for our patients and we charge what is usual and customary for our area of the county. You are responsible for payment regardless of any insurance company's (or any other benefit programs) arbitrary determination of what are usual and customary rates.
- **Privacy Policy:** I have read, and understand the Privacy Policy of this Practice, and know that any and all information obtained is strictly confidential.

The above conditions apply to services rendered by Clay City Pediatrics & Primary Care. The undersigned accepts these conditions.

Patients Name (Print):_____ Date:_____/_____/_____

Signature of Patient/Parent/Guardian:_____

Clay City Pediatrics
&
Primary Care

Date:_____

To Whom It May Concern:

I, _____, give permission for my child, _____ (date of birth) _____, to be supervised and medical decisions to be made by one of the following listed below if I am unable to bring him/her to the doctor's office.

_____ Relationship: _____

_____ Relationship: _____

_____ Relationship: _____

_____
Parent Signature

Mailing Address:
P.O. Box 648
Clay City, KY 40312

Office Location:
98 River Street
Clay City, KY 40312
Phone: 606-663-7788
Fax: 606-663-7785

E-mail: ccprimarycare1@att.net