WILLOWS PEDIATRIC GROUP, P.C. FAMILY REGISTRATION FORM

Billing Information_____ Date _____
(Please Print Name)

Billing Address_____ Telephone_____

_____ Emergency Contact: _____

Other Address _____ Emergency Contact # :_____

Email: _____ Referred By: _____

Insurance Information: Insurance Holder's Name _____

Primary Insurance Company _____ Policy effective date _____

Policy # _____ Group #_____
(CURRENT INSURANCE CARD MUST BE PROVIDED AT EVERY VISIT)

Family Information

Parent/Guardian _____ Parent/Guardian _____

SS#_____ DOB _____ SS#_____ DOB _____

Cell Phone _____ Cell Phone _____

Employer: _____ Employer: _____

Work # _____ Work # _____

Child: _____ DOB _____ SS# _____

Child: _____ DOB _____ SS# _____

Child: _____ DOB _____ SS# _____

Child: _____ DOB _____ SS# _____

Child: _____ DOB _____ SS# _____

AUTHORIZATION OF TREATMENT AND ASSIGNMENT OF BENEFITS:

I authorize Willows Pediatric Group P.C. to treat my child/children. I further authorize the release of medical information necessary for the completion of insurance forms. I authorize payment directly to Willows Pediatric Group P.C. for any and all medical or surgical benefits otherwise payable to me under the terms of my insurance. I also affirm that I will reimburse Willows Pediatric Group P.C. 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 charges not covered under my insurance benefits. I also understand that I am responsible for advising Willows Pediatric Group P.C. of any and all changes to my insurance coverage. Payment of co-pays are due on date of service. Failure to pay co-pay at that time will result in an additional administrative fee. Our office requires 24 hours notice for future appointment cancellation and rescheduling, or 4 hour notice for appointments made within 24 hours of the appointment time. Failure to provide this notice will incur a cancellation fee.

Signature:_____ Relationship:_____ Date:_____