UR HEALTH MEDICAL CENTERS, INC.
PEDIATRICS

UHMC, Inc –Pediatric Registration
PLEASE PRINT CLEARLY AND COMPLETE ALL INFORMATION

TODAY'S DATE: _____

How did you hear about us? ☐ Flyer/Postcard ☐ Friend/Family ☐ School ☐ Internet ☐ Brochure ☐ Insurance Company ☐ Sign in front of building ☐ Billboard ☐ Newspaper ☐ UMHC Patient: _____ Other: _____

PATIENT INFORMATION

Client's Name: _____ _____ _____
(Last Name) (Middle Name) (First Name)

D.O.B. _____ **Sex:** ☐ M ☐ F **Social Security#:** _____

Address: _____ **Apt. #** _____ **City** _____ **Zip** _____

Home Phone #: _____ **Other Contact #:** _____

Names of other children receiving services from our practice: _____

_____

Race: ☐ White ☐ Black ☐ American Indian ☐ Asian ☐ Native Hawaiian/Other Pacific Islander ☐ Multi-racial ☐ Other _____

Ethnicity: ☐ Puerto Rican ☐ Mexican ☐ Cuban ☐ Other Hispanic ☐ Haitian ☐ None of the Above

INSURANCE INFORMATION

PRIMARY INSURANCE INFORMATION:

Policy Holder: _____ **DOB:** _____ **SS#:** _____

Patient Relationship to Policy Holder: ☐ Self ☐ Child **Other:** _____

Insurance Name: _____ **Effective Date:** _____ **Co-Pay** _____

Insurance ID#: _____ **Group #:** _____ **Medicaid ID#:** _____

Assigned PCP: _____

Pharmacy Name: _____ **Pharmacy#:** _____

SECONDARY INSURANCE INFORMATION

Policy Holder: _____ **DOB:** _____ **SS#:** _____

Patient Relationship to Policy Holder: ☐ Self ☐ Child **Other:** _____

Insurance Name: _____ **Effective Date:** _____ **Co-Pay** _____

Insurance ID#: _____ **Group #:** _____ **Medicaid ID#:** _____

PARENT/ LEGAL GUARDIAN INFORMATION

Parent/Legal Guardian: _____

Social Security#: _____ **DOB:** _____

Address: ☐ **Same as Above:** _____ **Apt. #** _____ **City** _____ **Zip** _____

Home #: _____ **Work #:** _____ **Other** _____

Relationship to Patient: ___**Biological** ___**Step** ___**Adopted** ___**Foster** ___**Other:** _____

Email Address: _____

Employer: _____ **Employer Phone:** _____

EMERGENCY CONTACT INFORMATION

Emergency Contact Name: _____ **Emergency Contact Phone:** _____

Relation to Patient: _____

ACKNOWLEDGEMENT OF FINANCIAL AGREEMENT

Responsibility for Payment
I acknowledge that acceptance of my insurance information is not a guarantee of payment by my health plan until the claim has been accepted and processed. I further understand that if my claim is not accepted for payment I am personally responsible for payment of medical services rendered to me.

Responsibility for Co-Payments
I agree to pay all applicable health plan co-payments at the time of service. I understand that if (1) I do not pay my co-payments at the time of service, and if (2) an office billing statement is subsequently generated, I will be responsible for making full payment of any unpaid balance.

Payment Due Date
I understand that all health plan deductibles and charges for non-covered benefits are due and payable upon presentation of a billing statement from UR Health Medical Centers, Inc.

UR Health Medical Centers, Inc. sends billing statements for services rendered to a minor child under the age of 18 to the insurance Subscriber. All co-payments for minor children must be paid at the time of service by the parent/guardian who accompanies the child on the visit to the pediatrician.

PATIENT OR AUTHORIZED PERSON'S SIGNATURE. I acknowledge that I have read the above payment policies of UR Health Medical Centers, Inc and abide by them I further authorize the release of any medical or other information necessary process this claim.

SIGN HERE **Legal Guardian Signature:** _____ **Date:** _____

For Office Staff Only:

☐Head Start Patient ☐Copy of Insurance Card

☐ Copy of Legal Guardian Picture ID ☐Birth Certificate/Legal Documentation _____ Pediatric Staff Person's Initials