Date Completed	
Primary Care Provider	

Patient Registration Form (Please fill in all fields completely)

Patient Information

Child's Full Legal Name (Last, First, Middle)	Date of Birth	Sex	Preferred Name
Other Children in Family:			
Child's Street Address Child lives with: ☐ Mom ☐ Dad ☐ Both ☐ Other:	Telephone# where child lives:	Parent's Email Address: Mom: _____ Dad: _____	

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ White ☐ Other Race	Ethnic Group: ☐ Hispanic ☐ Non-Hispanic

Parent's/Legal Guardian's Primary Language:	Parent's/Legal Guardian's Primary Language:	Does the parent/guardian require an interpreter?
☐ English ☐ Spanish ☐ Other: _____	☐ English ☐ Spanish ☐ Other: _____	☐ Yes ☐ No

Parent Information

Mother's Name	DOB:	Home#	Work#	Cell#
Home Address				
Employer Name		Occupation		Driver's License#
Father's Name	DOB:	Home#	Work#	Cell#
Home Address				
Employer Name		Occupation		Driver's License#
Emergency Contact		Home#	Work#	Cell#
Relationship to Patient				

Who may we thank for referring you to our practice?	**Birth Hospital**

Guarantor Information (Person financially responsible)

Name		Relationship to Patient		Emancipated Minor? ☐ Yes ☐ No
Street Address		City	State	Zip
Date of Birth	Home#	Work#		Cell#
Employer Name		City	State	Zip

Insurance Information (if insurance is provided, please complete the information below)

Insurance Name		Telephone#
Subscriber ID#	Group#	Subscriber Employer
Subscriber Name		Date of Birth
Subscriber Address (If different than Guarantor)		Patient Relationship to Subscriber

FINANCIAL POLICY STATEMENT

Thank you for choosing Steeplechase Pediatric Center and allowing us to participate in your child's healthcare needs. We are committed to providing the best possible care for your children. Please read this statement so you will understand your financial responsibility and our payment policy.

Care delivered by this facility will be administered regardless of race, color, creed, social status, national origin, handicap or sex. It is our intent to never have the care of our patients compromised for financial reasons. Please contact our Business Office to make arrangements if needed.

ACCEPTANCE OF INSURANCE

- For all patients with active insurance coverage, a current insurance card is required to be shown at every visit. Our office's verification of benefits is not a guarantee of payment by your insurance company. It is the parent's responsibility to understand their own insurance coverage and to schedule their appointments with a doctor who is a participating provider with their insurance. One of our providers MUST be the Primary Care Physician prior to service for all HMO, EPO, and other PCP-required plans for correct benefits to apply. It is also the parent's responsibility to know where they can go for lab work and other services as referred by the pediatrician. Steeplechase Pediatrics will not be financially responsible for outside services.

RELEASE OF INFORMATION

- By signing this form, you authorize us to release any information as is necessary to collect from insurance companies and other third party payers.
- We may also disclose medical information as needed for the purpose of treating the patient.

RESPONSIBILITY FOR SERVICES RENDERED

- All parents and guardians are financially responsible for timely payment of medical services. We will file insurance claims for payment for services as a courtesy to the patient. The parent/guardian is ultimately responsible for payment and agrees to pay the account(s). Per the insurance contracts, the insurance payments will be sent directly to Steeplechase Pediatrics.
- The person bringing the child in for services is responsible for the charges that day unless previous arrangements have been made. If a person other than a legal guardian brings the child, copays, deductibles, or any non-covered charges are still to be paid at time of visit.

FINANCIAL RESPONSIBILITY OF DIVORCED PARENTS

- The parent who seeks the medical care for the child is responsible for any unpaid amount. Although divorced parents may have a divorce decree that establishes their financial responsibilities, we are not a party to the decree. We require the parent accompanying the child for treatment to accept primary responsibility for payment of those services.

NO SHOW/LATE CANCELLATION

- As a courtesy, our office will attempt to contact you about your well-child appointment one day prior; however, it is not our responsibility to ensure that you make your appointment. Our office requires at 24-hour advance cancellation notice to our office. Failure to comply subjects all private insurance members to a $25 NO SHOW fee. Your insurance company will not be billed for this, and you are solely responsible for paying in full. Texas Medicaid and CHIP patients will not be charged, nevertheless, our office will report each missed appointment (well or sick) to the appropriate Texas Medicaid/CHIP plan.

BALANCE ON ACCOUNT/BAD DEBTS/COLLECTIONS/LEGAL ACTION

- Balances are due within 30 days of the insurance payment, unless other satisfactory arrangements have been made with the clinic.
- Our office cannot become involved with any third party liability matters and we will expect payment from the parent/guarantor.
- Steeplechase Pediatrics reserves the right to request payment for outstanding balances. If the account is not paid in full or satisfactory arrangements made within a reasonable time frame, we reserve the right to refer the account to an attorney and/or a collection agency for collection of the balance.

By my signature, I state that I have read and understand the financial policy, and agree to all terms.

_____

Parent/Guardian Name Parent/Guardian Signature Date

_____

Witnessed by Steeplechase Pediatric Employee