Christakis Pediatrics
Patient Enrollment Form

Welcome to our practice! Please clearly print out the information requested. Thank you.

Patient Name:_____

Today's Date:_____ Date of Birth:_____Age:_____Sex_____

Whom may we thank for referring you to our practice?_____

Mother's Name (guardian)_____Date of Birth:_____

Address:_____Email:_____

Home Phone:_____Work phone:_____Cell:_____

Mother's Occupation/Employer:_____

Father's Name (guardian)_____Date of Birth:_____

Father's Occupation/Employer:_____

Father's Work phone:_____Cell:_____Email:_____

Name of Insurance/Policy Number:_____

Name of Primary Insured/Cardholder:_____

Information Release/Consent to Treat/Payment Responsibility

I hereby authorize:

1. Dr Paul Christakis to release any information concerning the patient to any health care professional or medical facility, necessary for coordination of care.
2. Any health care professional or facility to release all information concerning the patient to Dr Paul Christakis, necessary for coordination of care.
3. Dr Paul Christakis to release any information necessary for the processing of insurance claims for services provided.
4. Dr Paul Christakis or any medical professional filling in for Dr Christakis to examine and treat the above-named child.
5. Dr Paul Christakis to respond to any non-urgent medical queries by email, and I understand that email is not to be used in any case to communicate with our office in an emergency (instead, calling 911) or for other urgent or sensitive matters (instead, calling our office directly.)

I accept responsibility for payments of balances, copays, deductibles and the $325 annual practice/information fee.

I have read, understand and agree to the financial policies as outlined in the Christakis Pediatrics Financial Policy, available on our website, www.bocachild.com.

I agree that a copy of this signed agreement will be as valid as the original.

The information I have provided on this form is true and correct to the best of my knowledge.

Signature:_____Relation to Patient:_____

CHRISTAKIS PEDIATRICS, PA

SIGNATURE FORM

Please read and check the following statements in acknowledgment that you have read and understand the Financial, Privacy, and Immunization Policies of Christakis Pediatrics. These documents can be found at bocachild.com, where you can print and retain a copy for your records. Please bring this page with you to your next appointment.

_____I have read and understand the Christakis Pediatrics Financial Policy and agree to abide by the terms of the policy.

_____I have read and understand the Christakis Pediatrics HIPAA Patient Privacy Policy.

_____I have read and understand the Christakis Pediatrics Immunization Policy.

_____I understand that, if my insurance requires a copay, it is due at the time of service, and there is a $20 billing fee in the event that I do not pay at the time of service.

_____I understand that there is a $25 fee for missed appointments if not canceled 24 hours before the scheduled appointment.

_____I accept responsibility for payment of a $325 annual fee, per family, for website and other information sources.

Parent Signature_____

Print Name_____

Date_____

Please bring the New Patient Enrollment Form, Signature Page, Insurance Cards, and a copy of your child(ren)'s immunization record with you to your next visit.

Christakis Pediatrics, PA Financial Policy

We must have your correct insurance information on file at all times. If the office does not have the correct insurance information and the insurance company denies the claim, the policy holder is then responsible for all costs on that day.

As there are many insurance companies and innumerable different plans, it is parents' responsibility to know the provisions of your insurance plan. Please remember that the policy holder must abide by the contract that he/she has entered into with the insurance company. These provisions may include, but are not limited to:

- Use of a particular laboratory, outpatient imaging center or hospital appointed by your insurance company
- Need for a referral to see a specialist
- Requirement of pre-authorization for a service

If a copay is required by your insurance, the payment is due at the time of service. A $20 billing fee will be charged if it is not paid at that time. If your insurance plan includes a deductible, the contracted fee will be payable by you at the time of the visit. Accounts with outstanding balances greater than 90 days old will be considered to be in collection status. At that point, physicals and well baby checks will not be scheduled until the balance is paid, or a payment plan is arranged with our office.

We have implemented a 'credit card on file' policy to cover copays and balances. This will be an advantage to you, since you will no longer have to write a check and mail it. It will help us by decreasing the number of statements that must be mailed, which will keep costs down. Your ability to dispute your insurance company's charges will not be compromised using this process. Patients without insurance will still need to make full payment on the day of the visit and will require a credit card if paying by check.

Please feel free to ask any questions or speak with me about this policy, and thank you for your cooperation.

Jennifer Schanzle, Office Manager, Christakis Pediatrics, P. A.

I authorize use of this credit card for balances due and have read the policy statements:

Printed Name_____Signature_____

Date_____Credit Card _____Exp_____