Sage Hill Pediatrics
Kevin J. Rodbell, MD, FAAP

Patient Registration Form

PATIENT INFORMATION

Last Name: _____ First: _____ MI _____ Preferred: _____

SSN: _____-_____-_____ DOB: _____/_____/_____ Age: _____ Gender: M / F Insured: Y / N

Preferred Language: _____ Race: _____ Ethnicity: Hispanic / Non-Hispanic

Address: _____ City: _____ State: _____ Zip:_____

County: _____ Home Phone: _____ Cell Phone: _____

Mother's Maiden Name: _____

How did you hear about our office?_____

INSURANCE INFORMATION

Primary Insurance: _____ Subscriber: _____

Policy Number: _____ Group Number: _____

Secondary Insurance: _____ Subscriber: _____

Policy Number: _____ Group Number: _____

PARENT/GUARDIAN INFORMATION

Parent/Guardian 1 (PRIMARY CONTACT)

Name: _____ DOB: _____/_____/_____ SSN: _____-_____-_____

Address: _____ City: _____ State: _____ Zip:_____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

E-mail: _____ Employer: _____

Parent/Guardian 2

Name: _____ DOB: _____/_____/_____ SSN: _____-_____-_____

Address: _____ City: _____ State: _____ Zip:_____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

E-mail: _____ Employer: _____

Preferred Method of Communication: ☐ Home Phone ☐ Cell Phone ☐ Work Phone

I authorize SHP staff to: ☐ Send mobile text notifications about appointments

☐ Send voice notifications about appointments

Sage Hill Pediatrics

FAMILY WELLNESS WITH A PERSONAL TOUCH

Kevin J. Rodbell, MD

NO SHOW POLICY

Patient Name: _____ DOB: _____/_____/_____

Effective September 1, 2015 Sage Hill Pediatrics has implemented a *No-Show Policy*. 'No-Show' is when a patient misses an appointment without calling to cancel, or cancels too close to the appointment time. When this happens, we are not able to fill the appointment slot, and others who need to be seen may not get an appointment, because the schedule looks "full". Additionally, patients will be charged a $25 fee.

- **When canceling an appointment, we ask that you give at least twenty-four (24) hours notice.**

We understand that, on occasion, an emergency may prevent you from coming to an appointment. When this happens, we ask you to make a good-faith effort by calling us as soon as possible and the $25 fee will be waived.

The following count as a 'No-Show'.

- **Failure to show up for an appointment**
- **Arrival more than 15 minutes past a scheduled appointment time**
- **Cancellation with less than 24 hours notice**

In the event of a 'No-Show', as a courtesy, we will usually attempt to contact you by phone, mail, or e-mail; for this, we rely on you to keep your contact information updated in our files. However, after three 'No-Shows', whether or not you have received notices, you may be asked to find find another pediatrician.

Thank you for your consideration.

I have read and acknowledge the (above) Sage Hill Pediatrics No-Show Policy.

_____	_____	_____
Signature	Relationship to Patient	Date

Sage Hill Pediatrics

FAMILY WELLNESS WITH A PERSONAL TOUCH

Kevin J. Rodbell, MD

AUTHORIZATIONS

Patient Name: _____ DOB: _____/_____/_____

1. I hereby authorize and request the medical treatment necessary for the care of the above named patient.
2. I authorize the release of all medical records to the referring and family physicians and to my insurance company. If applicable, I allow the fax transmittal of medical records if necessary.
3. I acknowledge full financial responsibility for services rendered by Kevin J. Rodbell, M.D. I understand payment is due at the time of service unless other definite financial arrangements have been made prior to treatment. I understand I am responsible for any un-met deductibles and co-insurance fees.
4. I understand that insurance companies have agreements with certain laboratories for lab work and that it is my responsibility to know which laboratory my insurance authorizes and to inform the staff of Kevin J. Rodbell, M.D. as to which laboratory my insurance covers.
5. I further authorize and request that insurance payments be made directly to Kevin J. Rodbell, M.D. for services rendered.

I have read and fully understand the above consent for treatment, release of medical information, financial responsibility, and insurance authorization.

_____	_____	_____
Signature	Relationship to Patient	Date

INSURANCE POLICY

For the convenience of our patients, SHP has contracted with numerous insurance companies. We are pleased to be able to provide this service to you and to work with as many carriers as we can. It is not possible for our staff to keep track of all the individual requirements of each plan. Every plan has different stipulations regarding access to care and payment for services received. Within the same insurance company, benefits may differ depending on what type of contract you or your employer negotiated with that carrier on your behalf.

We are happy to provide care for our patients that falls within the guidelines of their insurance contract, but we ask that patients come prepared at the time of service to let us know what those guidelines are. ***Sage Hill Pediatrics personnel are not permitted to interpret insurance benefits for the patient***. We are expected and obligated to provide care to each insured person, but **it is the insured person's responsibility to understand his/her benefits.**

If you do not inform us of any special circumstances in your insurance contract, such as referrals or pre-authorizations for treatment, and we subsequently order services that are not covered, we will have no choice but to bill you directly for those charges. In the event that services are provided and your insurance coverage is not in effect on that day, or if your contract contains other exclusionary clauses, your insurance carrier will probably deny payment for services received. **Please remember that you, the patient, are ultimately responsible for payment on your account.**

Thank You,
Sage Hill Pediatrics Staff

I HAVE READ AND UNDERSTAND THE INSURANCE POLICY STATED ABOVE AND AGREE TO ACCEPT FINANCIAL RESPONSIBILITY AS DESCRIBED.

_____	_____	_____
Patient and/or Insured Signature	Printed Name	Date