Patient Registration

ALEXANDER PEDIATRICS, LLC

PATIENT INFORMATION

Name: _____ DOB: _____ Sex: M F

First Middle Last

SSN:_____

Physical Address:_____

Street City State Zip Code

Mailing address:_____

Street City State Zip Code

Mother's Name:_____ DOB:_____ SS#_____

Home Phone: _____ Work Phone:_____

Employer: _____ Occupation:_____

Driver's License #_____ State_____ Marital Status: S M W D

Name of Father: _____ DOB: _____ SS #: _____

Employer_____ Occupation_____ Work Phone:_____

Emergency Contact (Not Living with you)_____ Relationship_____

Home Phone: _____ Work Phone_____ Address_____

Referred to our office by: _____

Email Address (for patient portal): _____

RESPONSIBLE PARTY (Complete if different than patient)

Billing name_____ Relationship_____

Address:_____ Phone:_____

SS#_____ DOB: _____ Employer: _____ Phone:_____

PRIMARY INSURANCE INFORMATION

Name of insurance co: _____ Contract #_____Group #_____ Co-pay/Deductible $_____

Name of insured: _____ DOB:_____ Relation _____Effective date:_____

SECONDARY INSURANCE INFORMATION

Name of insurance co: _____Contract#_____ Group#_____ Co-Pay/Deductible $_____

Name of insured: _____ DOB:_____ Relation _____Effective date:_____

ASSIGNMENT OF INSURANCE BENEFITS/ AUTHORIZATION TO RELEASE INFORMATION

I understand that I am responsible for my account regardless of insurance coverage. I understand that I am responsible for all co-pays & deductibles at the time of service and that a late fee of $25.00 will be added to my outstanding balance if not paid within 30 days from time of service. I understand that I am responsible for all "routine" physical exams and preventative medicine procedures such as screening chest X-rays, screening EKG's, etc., if not covered by my insurance plan. I understand that I am responsible for any non-covered services regardless of insurance coverage. I understand that Dr. Jenny S. Alexander will do whatever is medically necessary for the maintenance of good health and, whenever possible, I will be notified of any non-coverage and will agree to pay for such services. I waive any right which I may have according to the Constitution of Laws in Alabama or any other state, to claim exemption as to personal property as to this obligation and if this obligation is not paid in full due, I agree to pay all costs of collecting it, including collection charges equal to 1/3 of outstanding balance, service charge $25.00 and late charges of 1½% per month (18% per annum). I understand that a service fee of $40.00 will be charged for all returned checks. I request that payment of authorized insurance benefits be made on my behalf to Dr. Jenny S. Alexander for all services furnished to me. I authorize any holder of medical information about me to release to my insurance company, any information needed to determine these benefits or the benefits payable or related services. I certify that the information given by me for payment of my account is correct. I authorize and consent to the rendering of routine, preventive and emergency care, including diagnostic procedures, medical and surgical treatments, blood transfusions, etc., by Dr. Jenny S. Alexander or authorized members of her staff, as may be necessary in their professional judgment for the above patient. I acknowledge that no guarantees have been made as to the effect of such examinations or treatment. I have been offered the option to review HIPPA compliance plan. I understand that Dr. Jenny S. Alexander provides outpatient medical care only and uses hospitalists for providing inpatient care.

Photocopies of these assignments shall be valid as the original

_____ _____

Signature **Date**

Signature of Patient or Legal Guardian **Date**