



Ching's Pediatrics
Rebecca Ching, M.D.
REGISTRATION FORM

Section I

Patient Information

Date _____

Name _____ **Date of Birth** _____ **Gender** M or F

Race American Indian _____ Asian _____ African American _____ Other _____ White _____ Refuse to report

Ethnicity Hispanic _____ Non Hispanic _____ Refuse to report _____

Preferred Language _____ If parents are divorced, who is the custodial parent? _____

Mailing address _____ **City** _____ **State** _____ **Zip** _____

Phone# () _____ **Cell#** () _____ **Name of school** _____

E-mail for Web Portal _____

Mother/Legal Guardian:

Name _____ **Date of Birth** _____ **Phone#** _____

Mailing address _____ **City** _____ **State** _____ **Zip** _____

Employer _____ **Work#** _____ **Social Security #** _____ - _____ - _____

Father/Legal Guardian:

Name _____ **Date of Birth** _____ **Phone#** _____

Mailing address _____ **City** _____ **State** _____ **Zip** _____

Employer _____ **Work#** _____ **Social Security #** _____ - _____ - _____

Do you authorize us to obtain your medication history from our database? Yes or No

Whom may we thank for referring you? _____

Emergency contact **NOT LIVING WITH YOU** _____ **Relation to patient** _____

Emergency contact phone# _____

Names of other children: _____

I, _____, give permission for _____ (not including spouse) to bring my child in for any medical treatment deemed necessary and/or well-child visits. **Including immunizations?** Yes or No

Section II**Responsible Party**

Relationship to Patient _____ Self _____ Father _____ Mother _____ Other _____
Name _____ Date of Birth _____ Phone# _____
Mailing address _____ City _____ State _____ Zip _____
Employer _____ Work# _____ Social Security # _____ - -
Employer's Address _____

Section III**Primary Insurance Information**

Policyholder _____ Date of Birth _____ Relationship to Patient _____
Mailing address (if different from above) _____ Same as above? Yes or No
SSN# _____ Employer _____ Work # _____
Insurance Company _____ Group# _____ ID# _____
Claims Address _____ Insurance phone# _____
Do you have a secondary insurance? If yes complete the following: ☐ Yes or ☐ No

Secondary Insurance Information

Policyholder _____ Date of Birth _____ Relationship to Patient _____
Mailing address (if different from above) _____ Same as above? Yes or No
SSN# _____ Employer _____ Work # _____
Insurance Company _____ Group# _____ ID# _____
Claims Address _____ Insurance phone# _____

OFFICE POLICY

24-hour notice is required for cancellation of an appointment. If you do not call within 24 hours of your appointment or if you do not show up for an appointment 3 times in a calendar year, you will be charged a \$35.00 no show fee. This fee is not reimbursed by your insurance company. **IT IS THE PATIENT'S RESPONSIBILITY AND YOU WILL BE REQUIRED TO PAY THE NO SHOW FEE BEFORE FUTURE APPOINTMENTS WILL BE SCHEDULED.**

I understand and agree to the terms above,

Parent/Guardian Signature

Date

CHING'S PEDIATRICS
Rebecca Ching, M.D.
REGISTRATION FORM (cont....)

Financial Agreement, Assignment of Benefits & Release:

In Accordance with the Federal Truth in Lending Act, please be advised of the following financial policies which apply in the office.

- As the guarantor/patient (18 or older), you are the responsible party, and as such, you are responsible for the payment of the bill, regardless of your insurance type-including Medicaid and Workman's Comp, or any other third party involvement.
- As the responsible party, you agree to pay the doctor at the time service is rendered, unless other financial agreements have been made with the business office. If our Physician is a preferred provider with your insurance company, all deductible amounts and copays are due at time of service.
- The responsible party will cover the balance of this account within 90 days from the date of service in the event the insurance company does not pay the entire balance within that time. A collection fee of 50% from the unpaid balance will be added to after a 90-day period.
- A \$35.00 fee will be added in the event of a returned check.
- The responsible party agrees to pay for all attorney fees, court costs, and filing fees of the principal balance as well as any collection fees that a collections agency may charge in the event that the account must be referred to a collection agency.

Note: Certain services are not billed through our facility, and will results in a billing statement from another company (i.e. outside lab work, MRI's, x-rays and other radiology tests).

Informed Consent: I hereby authorize the physician and/or such associates or assistants he/she may designate to perform a physical examination and to advise me in further appropriate care as he/she may deem necessary or advisable to my medical treatment. I do voluntarily assume any and all possible risks, including the risk of substantial harm, if any, which may be associated with treatment procedures, routing immunizations or other medical treatments in hopes of obtaining the potential desired results, which may or may not be achieved, as no medical benefit is guaranteed.

Note: Failure to complete this form will results in delays with insurance, therefore you may be billed in full if we do not have all necessary information.

Patient/Responsible Party Signature: _____ Date: _____

Assignment of Insurance Benefits: I, the undersigned, give permission to release information to third party carrier(s) and do assign all insurance benefits for treatment to be paid directly to my provider. I certify that a copy of this assignment shall be as valid as the original.

Patient/Responsible Party Signature: _____ Date: _____