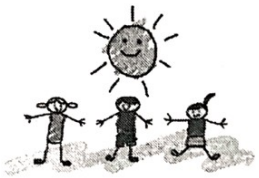

Pavilion Pediatric Center, LLC

Prakash Bhoopalam, MD **Dr. Afshan Jabeen**
Nicole Rector, CPNP-PC **Chasity Evans, DNP**
Phone: (765) 231-9494 *Fax: (765) 587-4456*

Patient Registration Form

(PLEASE COMPLETE ALL INFORMATION)

PATIENT INFORMATION: **Today's Date:** _____

Child #1 Name: _____
Date of Birth: _____ Sex: ☐ M ☐ F

Child #2 Name: _____
Date of Birth: _____ Sex: ☐ M ☐ F

Child #3 Name: _____
Date of Birth: _____ Sex: ☐ M ☐ F

Child #4 Name: _____
Date of Birth: _____ Sex: ☐ M ☐ F

Child #5 Name: _____
Date of Birth: _____ Sex: ☐ M ☐ F

PARENT/GUARDIAN INFORMATION:

Primary Family Email: _____

Primary Family Phone: _____

Primary Mailing Address: _____

City: _____, **State:** _____ **Zip:** _____

Mother/Stepmother/Guardian:
Last Name: _____ First Name: _____
Date of Birth: _____ Social Security Number: _____
Address (If different from above): _____
City: _____ State: _____ Zip: _____
Primary Phone #: _____ Secondary Phone #: _____
Employer: _____ Marital Status (M/D/S) _____

Father/Stepfather/Guardian:
Last Name: _____ First Name: _____
Date of Birth: _____ Social Security Number: _____
Address (If different from above): _____
City: _____ State: _____ Zip: _____
Primary Phone #: _____ Secondary Phone #: _____
Employer: _____ Marital Status (M/D/S) _____

We are required to collect the following information for each patient.

Please complete this section before returning the form. Thank you!

1) Preferred Primary Provider:
(Circle One)

DR BHOOPALAM **DR JABEEN**

N.RECTOR **C.EVANS**

2) Preferred Pharmacy:

Name: _____

Location: _____

3) Your Preferred Language:

_____

4) Your Child's Race/Ethnicity:
(select one primary)

- ○ American Indian
- ○ Asian
- ○ Black/African American
- ○ Caucasian
- ○ Hispanic
- ○ Multiracial
- ○ Unknown
- ○ Other _____

FORM COMPLETED BY:
Name (Print) _____ Signature: _____ Date: _____

PAVILION PEDIATRIC CENTER, LLC

INSURANCE INFORMATION

Today's Date:_____

PRIMARY INSURANCE:

Insurance Plan:_____ Effective Date:_____

Policy Number:_____ Group Number:_____

Policy Holder Name:_____ Policy Holder Date of Birth:_____ Sex: ☐ M ☐ F

Name(s) of Children covered on this Policy:_____

SECONDARY INSURANCE:

Insurance Plan:_____ Effective Date:_____

Policy Number:_____ Group Number:_____

Policy Holder Name:_____ Policy Holder Date of Birth:_____ Sex: ☐ M ☐ F

Name(s) of Children covered on this Policy:_____

HAVE/WILL YOU BE APPLYING FOR MEDICAID COVERAGE? ☐ YES ☐ NO

****PLEASE NOTE: The insurance policy holder is not automatically the Billing Guarantor. The Parent/guardian who is present for office visits is the Billing Guarantor, please see below****

NOTICE OF FINANCIAL RESPONSIBILITY

Billing Guarantor

I understand that payment of all medical care is dues at the time of service. The parent and/or legal guardian who signs this form is responsible for any and all co-pays, deductibles, co-insurance, and/or unpaid balances not covered by insurance, regardless of marital status. I understand that I am responsible for any costs incurred in the collection of a patient's account in case of default, including reasonable attorney fees and court costs.

I hereby grant permission to Pavilion Pediatric Center, LLC to release any pertinent information to my insurance company upon request, and I also authorize payment directly to Pavilion Pediatric Center, LLC. A photocopy of this authorization shall be considered as effective and valid as the original.

NON-COVERED SERVICES

I am aware that some services performed by Pavilion Pediatric Center, LLC may be considered "non-covered" by my insurance carrier or Medicaid, therefore I will become fully responsible for payment of these services.

DIVORCE/CHILD CUSTODY

Pavilion Pediatric Center, LLC will not honor the specific financial arrangements set forth in a Child Custody Agreement, Divorce Settlement Agreement, Divorce Decree from Judgment, or the like (the "Arrangements"). Since PPC is not a party to these Arrangements, it is not obligated to the financial terms of these Arrangements.

In cases of child custody, the parent who presents their child (the "Presenting Parent") for care and treatment at PPC is responsible for the payment of co-pays, co-insurance, and deductibles at the time of service. This policy applies whether there is a joint-custody arrangement of the child and/or joint responsibility for their medical expenses. If the child is on the non-custodial or non-presenting parent's health insurance, then PPC will still collect the applicable co-pays, coinsurance, and deductibles at the time of service from the Presenting Parent. Upon request, PPC will provide a duplicate copy of your receipt so that the Presenting Parent or guardian can seek reimbursement where appropriate.

NOTICE OF PRIVACY PRACTICES

I have reviewed this office's Notice of Privacy Practices, which explains how protected health information (PHI) will be used and disclosed. I understand that Pavilion Pediatric Center, LLC has the right to change its Notice of Privacy Practices that will be effective for health information the practice already has about my child[ren], as well as any they receive in the future. PPC will post a current copy of the Notice. I understand I may receive a copy of the current Notice upon request.

☐ **I have read all of the above and understand/agree to all provisions therein regarding financial responsibility, permission for treatment, and Notice of Privacy Practice.**

BILLING GUARANTOR SIGNATURE

_____	_____	_____
Billing Guarantor Name (Print)	**Date of Birth (mm/dd/yyyy)**	**Signature**

PERMISSION TO TREAT

I (We)_____ **authorize Pavilion Pediatric Center, LLC and its**
Print Name(s) of legal gardian(s)
personnel to deliver medical services to my child(ren), listed below:

(Please Print)

Name:_____ Date of Birth:_____

Name:_____ Date of Birth:_____

Name:_____ Date of Birth:_____

Name:_____ Date of Birth:_____

Name:_____ Date of Birth:_____

Name:_____ Date of Birth:_____

I (We) authorize the following people to bring my child(ren) in for treatment, and/or to contact in case of an emergency:

Name:_____ Phone:_____ Relationship:_____

Name:_____ Phone:_____ Relationship:_____

Name:_____ Phone:_____ Relationship:_____

Name:_____ Phone:_____ Relationship:_____

_____ _____

Signature(s) of Legal Guardian(s) **Date**

_____ _____

Primary Phone **Relationship to patient**

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand I am entitled to receive a copy of this document.

PLEASE INITIAL ONE

_____ I request to have a printed copy of the Notice of Privacy Practices.

_____ I decline a printed copy of the Notice of Privacy Practices.

List each child that is seen at our practice (Please Print):

Child's First Name	Child's Last Name	Date of Birth

2525 W University Avenue, Suite 404
Muncie, IN 47303