Coastal Healthcare Patient Registration – Today's Date _____

Patient's Name _____

Address _____ City_____ Zip _____

Patient's Date of Birth _____ Phone _____

e-Mail _____

Pharmacy _____ Address/Phone _____

Father _____ Mother_____

Father's Date of Birth _____ Mother's Date of Birth _____

Social Security # _____ Social Security # _____

Occupation _____ Occupation _____

Employer _____ Employer _____

Cell Phone _____ Cell Phone _____

Please tell us who referred you _____

Insurance Company _____ ID# _____

Subscriber's Name/Address _____

Private Insurance Authorization Assignment of Benefits/Information Release:
I, the undersigned, authorize payment of a medical benefit to Coastal Healthcare for any services furnished me by the physician. I understand that I am financially responsible for any amount not covered by my insurance. I also authorize you to release to my insurance company information concerning healthcare, advice, treatment, or supplies provided to me. This information will be used for the purpose of evaluating and administering claim benefits.

Responsible Party _____ **Date** _____

In case of emergency, I authorize the following person to bring my child for medical care:

Name _____ Relationship _____ Phone _____
Name _____ Relationship _____ Phone _____

Race: (check one below)
_____ American Indian or Native Alaskan
_____ Asian
_____ Native Hawaiian or Other Pacific Islander
_____ Black or African American
_____ White
_____ Hispanic
_____ Other Race
_____ Other Pacific Islander
_____ Unreported or refused to report

Ethnicity: (check one below)
_____ Hispanic or Latino
_____ Not Hispanic or Latino
_____ Refused to Report

Language other than English:
_____

Preferred Lab:
_____

Please sign ONE of the following consents:

IMMUNIZATION CONSENT

I give permission for my child to receive immunizations as per the American Academy of Pediatrics guidelines.

Parent/Guardian Signature Date

~ OR ~

IMMUNIZATION REFUSAL

I am REFUSING Immunizations for my child at this time. It has been explained to me that the risks of not vaccinating my child may result in serious, life threatening illness and disease.

Parent/Guardian Signature Date

Coastal Healthcare

OFFICE POLICY

Coastal Healthcare's goal is to provide and maintain a good physician-patient relationship. We start with skilled professional physicians and staff who recognize the importance of good communication on all levels.

1. CHECK IN:

- *Upon arrival, please check in at the front desk. For your initial visit, present a photo ID such as a driver's license and your Insurance Card. You will be asked to complete registration forms. Any payment due by patient is requested during check in.*
- *At all visits thereafter, check in at the front desk, present your current insurance card and any payment due at EVERY visit. Please inform us of any changes to your personal information such as address, phone or insurance.*

2. MEDICATION REFILLS:

- *All refills are done based on patient's adherence to scheduled appointments and medical necessity. Please be prepared to review your medication refill needs at the time of your visit. Contact your pharmacy to request refills outside of scheduled appointments as prescription refills are done electronically to and from your pharmacy. Please call your pharmacy first for your refills. They will contact the office. If you prefer a 3 month mail order, please allow ample time for the order to be processed and received through the mail. Refills for certain class drugs will need to be picked up at the office.*

3. INSURANCE: Under the guidelines of your insurance plan, it is your responsibility to understand your benefit plan.

- *REFERRALS/AUTHORIZATIONS: It is your responsibility to know if a referral or authorization is required to see a specialist. Three (3) business days is requested for non-emergent referrals and authorizations.*

*PATIENT SIGNATURE:*_____ *DATE:*_____

Coastal Healthcare

FINANCIAL POLICY

Welcome to Coastal Healthcare. We would like to take this opportunity to inform you of our office financial policies.

Insurance and Billing:
We will bill insurance claims to primary and secondary carriers as a courtesy to our patients. You are responsible for providing us with up-to-date insurance information. If your insurance company requires referrals, advanced notification is required for non-emergent referrals. Also, when coming to a Coastal Healthcare specialist, you must have your referral before being seen or you will be responsible for payment in full at the time of service. We accept payment from all participating insurance plans, but require that you pay your co-pay at the time of service. You will be responsible for any deductibles, coinsurance and non-covered services. If you do not have insurance, payment for services is expected at the time of service. The office policy is that the parent requesting treatment for a minor child is responsible for all fees incurred. We cannot become involved in billing disputes in cases involving divorce or separation.

Insurance policies have become increasingly complex over the years and it has become impossible for our office to know each specific plan and their limitations. Therefore, it is your responsibility to know your insurance benefits. Your insurance policy is a contract between you and your insurance company. You may be billed in the event that your insurance plan does not pay in a timely manner or is unresponsive to our claims submission. All fees are ultimately your responsibility.

Charges/Fees:
All missed appointments with the doctor and those cancelled with less than 24-hour notice may be subject to a $25.00 fee. Also, in the event that a check is returned to us by your bank for any reason, there will be a $25.00 service charge. There may be additional charges, not covered by insurance, including form processing fees (i.e., physicals, disability), after-hours appointments, weekend appointments, appointments on holidays, and a processing fee on over 30 day unpaid balances ($10 per statement).

Collection Agency:
All patient accounts that become delinquent will be processed in-house for collection proceedings. A past due and final dunning notice will be sent for overdue accounts. The account will then be reviewed for referral to an outside agency. All accounts turned over to a collection agency will be assessed a 25% administrative fee.

Financial Hardship:
Financial hardship should not stand in the way of medical care. Please discuss hardship with the billing staff as soon as possible.

I HAVE READ AND UNDERSTAND THE TERMS AND CONDITIONS SET FORTH IN THE ABOVE POLICY.

_____ _____

Patient Name-Please Print Date

_____ _____

Patient or Parent Signature Relationship

Coastal Healthcare

ACKNOWLEDGEMENT OF PRIVACY PRACTICE NOTICE AND DESIGNATION OF DISCLOSURE FORM

1. **Acknowledgement of Privacy Practice Notice:**
   I have been offered a copy of ***Coastal Healthcare's*** Notice of Privacy Practices.

   Patient Name: _____ Date of Birth_____

2. **I wish to be contacted in the following manner (check all that applies):**

   Home Telephone (OK to leave a detailed message) Number: _____
   □ Check if it is **not** ok to leave a detailed message on your answering machine and a message with only the Doctor's name and number will be left.

   Cell Telephone (OK to leave a detailed message) Number: _____
   □ Check if it is **not** ok to leave a detailed message on your cell phone and a message with only the Doctor's name and number will be left.

   Work Telephone (OK to leave a detailed message) Number: _____
   □ Check if it is **not** ok to leave a detailed message at work and a message with only the Doctor's name and number will be left.

   Written Communication: Unless otherwise instructed written communications will be mailed to the home address on file.

3. ***Coastal Healthcare*** operates as a multispecialty group with various offices that have access to your information and may exchange the details from our shared database.

4. **Designation of Certain Relatives, Close Friends and Other Caregivers:**
   I agree that ***Coastal Healthcare*** may disclose certain of my health information to a family member, close friend or other caregiver because such person is involved with my health care or payment relating to my healthcare. In that case, ***Coastal Healthcare*** will only disclose only information that is relevant to the person's involvement with my health care or payment relating to my health care.

   I designate the following person listed below as a person involved with my healthcare or payment relating to my healthcare for the purposes of ***Coastal Healthcare*** to make the type of disclosures listed above. (I understand that I am not required to list anyone and that I may change this list at any time in writing).

Print Name (other than patient) 1) _____ 2) _____

Relationship to Patient: 1) _____ 2) _____

Date of Birth: 1) _____ 2) _____

Telephone #: 1) _____ 2) _____

_____ _____
Signature of Patient/Parent/Guardian Date