melmed center

TM

REGISTRATION FORM

MUST BE COMPLETED IN FULL USING A **BLACK** INK PEN

Patient information

Legal Name _____**Date of Birth**_____ **M/F**____
Child lives with: Mother □ Father □ Court Appointed Guardian: _____

Mother / Court Appointed Guardian Information ***(Paperwork must be provided for legal Guardians)***

Name_____**Date of Birth**_____
Address_____ **City** _____ **State** _____ **Zip** _____
Primary Phone #_____ **Secondary Phone** _____
E-MAIL: _____ ***would you like to receive updates via E-mail?*** **Yes / No**
If parents are divorced or separated, Mother has a right to request records and coordinate care? Circle Yes/ No
If no please explain: _____

Father / Court Appointed Guardian Information ***(Paperwork must be provided for legal Guardians)***

Name_____**Date of Birth**_____
Address_____ **City** _____ **State** _____ **Zip** _____
Primary Phone #_____ **Secondary Phone** _____
E-MAIL: _____ ***would you like to receive updates via E-mail?*** **Yes / No**
If parents are divorced or separated, Father has a right to request records and coordinate care? Circle Yes/ No
If no please explain: _____

I authorize Melmed Center to contact me by telephone with medical information pertaining to my child's care. If I am unavailable, this authorization gives Melmed Center permission to leave this information either on my answering machine or with a member of my household.

Authorized Care Givers ***(Other than biological parents/guardians)***
The following people are authorized to discuss personal health information with the Melmed Center. They are also able to coordinate care, schedule and attend appointments and may be contacted in case of an emergency.
(Only parents and legal guardians can request and transfer records)

Name _____ **Relationship** _____**Phone Number** _____

Name _____ **Relationship** _____**Phone Number** _____

PLEASE NOTE IF DIVORCED: LEGAL CUSTODY DOCUMENTS MUST BE PROVIDED

DIVORCED/SEPARATED FAMILIES
We strive to, but cannot always act as a mediator between parents under contentious circumstances. We also strive to avoid being "side-barred" by parents, lawyers or other professionals; and we hope that is respected. Both parents are always welcome, explicitly and implicitly, at all visits; indeed that is preferred. Parents are responsible for ensuring that coordination of each of their own schedules allows for both to be present. This of course requires a degree of cooperation, that if absent, will preclude the most optimal evaluation. If communication challenges exist which preclude that, it is unfortunate, especially for the child. Melmed Center will work with both parents. Therefore, it is required that you complete both parents information above unless the court dictates otherwise. Furthermore, payment must be arranged by the time of the visit. We accept payment in advance, but require it from the accompanying adult at the time of the appointment.

I UNDERSTAND AND AGREE TO ALL OF THE ABOVE_____ **Date** _____
Signature of Parent/Legal Guardian

Please turn the page over and complete the other side →

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CANCELLED/MISSED APPOINTMENTS

A scheduled appointment means that time is reserved only for you. **If an appointment is missed or cancelled for any reason, with less than 48 hours notice, the patient will be billed according to the scheduled fee**. This fee is generally not paid by an insurance company. ***Initial:*** **_____**

PRESCRIPTION REFILL POLICY

Our office policy is that all prescription refill requests must be made 7-10 working days in advance of running out of the medication. Refills will only be approved if follow up visits have been kept **every 2-3 months**.
Prescriptions will be handled only during office hours. ***Initial*****: _____**

The Melmed Center has therapy/service animals in our office. **It is your responsibility** to notify our office, **prior to your appointment**, if you have fear of, or allergies to dogs. Melmed Center will not be held liable for any incidents such as licking, nibbling, or physical contact from the dog(s). By signing this document you are aware we do have service/therapy animals in our office. Please contact us if you have any further questions.

FINANCIAL RESPONSIBILITY

We charge what is usual and customary for our area. Our office policy is that full private payment or insurance co-payment/co-insurance and/or deductible, as well as, account balances are due at the time of service unless prior arrangements have been made. The adult accompanying the minor patient will be required to pay in accordance with our policies.
Please understand that we will only bill insurance companies that we are contracted with. Furthermore, it is your responsibility to follow up with the insurance company to insure the claim is paid within 60 days of the date of service. We must emphasize, that as health care providers, our relationship is with you, our patient, and NOT with your insurance company. You are responsible for knowing what your insurance benefits are, including what your insurance will and will not pay for; and how to access your benefits, including obtaining referrals, etc. If you are unsure, please contact your insurance carrier. This office assumes no responsibility for your lack of knowledge regarding your insurance benefits. You are responsible for any remaining unpaid charge(s) as determined by your insurance company regardless of cause. This agreement is necessary in order to accept your insurance without having to bill you upfront. An account past due 60 days or more and payment plans that are not kept current may be subject to collection and associated fees.

Please note: Insurance cannot be billed without the patient present. Upon request you may schedule a parent consultation with your child's provider for a private pay fee.

By completing the information below, you assign your insurance benefits to be paid directly to Melmed Center. You also authorize Melmed Center to release any information which may be needed for processing all of claims; certification/case management/quality improvement; and/or other purposes related to the benefits of your health plan. Furthermore, understand that it is your responsibility to ensure that proper referrals or authorizations are obtained for each visit. Finally, **we require notification of insurance changes at least one week prior** to your appointment to avoid appointment delay and/or private pay expenses.

Insurance Company: _____ Phone: (___)_____ Employer: _____

Group/Policy#: _____ ID#: _____ Employee SS#: _____

Employee/Insured's name: _____ DOB: _____

Insurance Mailing Address: _____

Some medications may require Prior Authorization. Please call your insurance company and find out what provider your PHARMACY BENEFITS are covered through. Please note: This may be located on your insurance card (i.e. Medco, Prescription Solutions, Caremark, and Express Scripts), **if not, we do need this information filled out in its entirety.**

Pharmacy Benefit Provider: _____

I UNDERSTAND AND AGREE TO ALL OF THE ABOVE_____ **Date** _____

Signature of Parent/Legal Guardian