Southpointe Pediatrics
8851 Southpointe Drive Suite C1 Indianapolis IN 46227

PATIENT REGISTRATION INFORMATION

Patient Legal Name _____ Birth Date _____ Age _____
Last First MI

Address _____ Sex assigned at birth: _____ Gender Idenity: _____
Street Apt #

_____ Home Phone ( ) _____ Date _____
City State Zip

Patient Lives With: Mother Father Both Other _____ Race:_____

Preferred Gender Pronoun(s): _____ Child's preferred name _____

Parent or Legal Guardian #1 Relationship to patient: _____ Responsible for bill Y N

Name _____ Birth Date _____
Address _____ Soc. Sec. # _____
City, State Zip _____ Home Phone ( ) _____ Cell Phone ( ) _____
Employer _____ Work Phone ( ) _____ Ext. _____

Parent or Legal Guardian #2 Relationship to patient: _____ Responsible for bill **Y** **N**

Name _____ Birth Date _____
Address _____ Soc. Sec. # _____
City, State Zip _____ Home Phone ( ) _____ Cell Phone ( ) _____
Employer _____ Work Phone ( ) _____ Ext. _____

Additional Contact (friend, neighbor, aunt, uncle, etc.) Medical information **WILL NOT** be disclosed regarding the patient.

Name _____ Home Phone ( ) _____ Work Phone ( ) _____
Address _____ Cell phone ( ) _____

Email address for communication on appointments and billing _____

**** Parents or Legal Guardians are the only ones who can bring the child in to seek treatment UNLESS we have legal documentation/verbal consent stating otherwise.**

If a Parent or Legal Guardian listed above has a spouse, please complete the section below:

Stepparent Information
Name _____
_____
_____
_____
Work Phone ( ) _____
Cell Phone ( )

Stepparent Information
Name _____
_____
_____
_____
Work Phone ( ) _____
Cell Phone ( )

Please list all of this child's siblings that are currently being seen here:

_____ _____
Name Birth Date Name Birth Date

_____ _____
Name Birth Date Name Birth Date

I give my consent and authorization for the disclosure to the personal representatives I list below to have the right to receive medical advice for the minor listed on this form via telephone should I not be present or available by phone. This consent does not allow the personal representatives to bring in the minor for an appointment.

Name: _____ Relationship:_____

Name: _____ Relationship: _____
Name: _____ Relationship: _____

OFFICE POLICIES

1. Your copayment, insurance allowable deductible, and coinsurance amount are due at the time of service. Amounts not paid at the time of service will be subject to a late fee 10 days from the date of service. It is your responsibility to know your insurance benefits. Benefits given to us by your insurance company are "quotes" only and is no guarantee of payment. Our office is an approved site to provide VFC vaccines on behalf of the health department. Any patient eligible for these vaccines will have them given here. We are required by the state that the given vaccines are entered into the online state Children and Hoosiers Immunization Registry Program. Effective 7/1/15, all vaccines, private and VFC stock will be entered into the online state registry. We require that your child be seen for a complete well child physical examination as recommended by the American Academy of Pediatrics which is detailed below:

1 or 2 weeks	4 months	12 months
1 month	6 months	15 months
2 months	9 months	18 months

   then, at 2 years of age, 2 ½ years and then yearly after that.
   School, daycare, or sports forms will not be completed if the patient is not up to date on this well care schedule. Indiana High School Athletic Association requires children from middle school age through high school to have their annual exam done April 1st or after each year. Noncompliance with our well child policy will result in discharge from the practice.
2. It is in your child's best interest that he be seen before antibiotics are prescribed and considering that, prescriptions for antibiotics are not routinely called in without an examination.
3. Patients are seen by appointment only. We ask you to schedule an appointment for all the children needing to be examined. Siblings brought in with another child will not be seen, as this causes delays in patients who are waiting that already have an appointment. Children will be seen on a walk-in basis for emergencies only; this does not include routine sickness.
4. Routine telephone questions will be answered by nursing personnel after consulting the physician. The doctor will answer questions requiring their expertise only or the physician feels a direct phone call back to the parent necessary. The physician call back will be at their earliest convenience unless an emergency indicates otherwise.
5. Your child will see the same physician for all well care examinations unless scheduling issues arise which will be determined by a physician during peak seasons.
6. There will be a charge plus postage fee for copying medical records. This fee is not billable to your insurance company. There are fees associated with the completion of daycare, school, sports, camp, etc. forms. A fee also applies to the completion of FMLA paperwork. Fees for forms must be paid in advance of forms being completed. Form fees are not billable to your insurance company.
7. **PATIENTS ASSIGNMENT AND AUTHORIZATION TO RELEASE INFO FOR PAYMENT**: To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize release of any information regarding services rendered and a allow a photocopy of my signature to be used to file insurance and direct by insurer to issue payment for all medical and or surgical benefits to me for services rendered, direct to the provider. This assignment and authorizations will remain in effect until revoked by me in writing. I understand that I am financially responsible for the fees for all services rendered. In addition, I/we hereby designate Southpointe Pediatrics, PC and its employees as my/our representative to file grievances and to represent me/us in accordance with the Indiana Code, Title 27, Chapters 8 and 13. I have read the above and fully understand the terms thereof.
8. My signature below acknowledges my receipt of this facility's Notice of Privacy Practices.
9. I, the undersigned parent, or legal guardian of this minor do hereby authorize and consent to any medical exam or treatment rendered under the general or special supervision of a duly licensed physician, licensed under the provisions of the laws in the State of Indiana. It is understood that this authorization is given in advance of any specific diagnosis, treatment or medical care being required but is given to provide authority and power to render care, which the physician in the exercise of his best judgement may deem advisable. It is understood that effort shall be made to contact a parent or legal guardian prior to rendering treatment to the patient, if consent for someone other than the parent or legal guardian to bring the child in was not obtained, but that any of the above treatment will not be withhold if the parent or legal guardian cannot be reached.
10. Should you bring in or mail us a photo of your child and or family, the office has your permission to display the picture in our office which could be viewed by the public.

Signature: _____ Date: _____