Registration Form

Thank you for the honor of choosing SEE Alternatives Pediatrics (SEEAP) for the healthcare of your child. We are committed to partnering with you to provide the best healthcare for your child with the goal of optimal physical, emotional and mental health.

Patient Name ____ **Date of Birth:** _____________________

Primary Contact Phone: __________________________ **Email:** ___________________________________

Mother's Name: _____________________________________ Phone:_____________________________

Father's Name: _____________________________________ Phone:_____________________________

Address (Including City & State):

____

Insurance Information ☐Not applicable, Self-pay

Primary Insurance Policy Name: ____

Insurance Policy & Group Number: ____

Policy Holder's Name: ____

Policy Holder's Date of Birth: ______________________________

Policy Holder's Social Security Number: ___________________________

Please initial on highlighted lines.

Consent to Treat

_____ I authorize SEEAP to provide medical care to my child that is necessary and appropriate.

_____ I authorize SEEAP to access prescription medication data for the purpose of treating my child.

Signature of Parent/Guardian: ____ **Date:** _____________

I, being the parent or guardian of the above listed minor child, do hereby request and authorize any provider and staff of SEEAP to perform necessary services for my child which are deemed advisable by the provider, when I am not present at the actual appointment. I understand that without written authorization from a parent or guardian, treatment may be delayed or refused until authorization is provided. Below is a list of individuals who have permission to bring my child in for treatment:

Signature of Parent/Guardian: ____ **Date:** ______________

Patient Name: ____ Date of Birth: ____________________

By initialing and signing below, you indicate that you have reviewed and understand our policies and procedures:

_____ I understand I have access to SEEAP's Notice of Privacy Practices on our website, in our office, and upon request.

_____ I authorize SEEAP and Patient Fusion to communicate with me via text and email at the primary contact listed above for appointment reminders, messages from providers, and other general communication regarding my child's care. I authorize SEEAP to add my email to an email list for the purpose of providing educational information and updates regarding the practice.

_____ I understand the co-payment outlined by my contract with the insurance company is expected in full at the time services are rendered. I understand that if SEEAP does not collect the co-payment, SEEAP is in violation of a binding agreement with the insurance company.

_____I authorize SEEAP to release any medical information necessary to my insurance carrier to obtain reimbursement for services rendered to my child/dependent.

_____I hereby authorize direct payment of benefits payable for these services SEEAP. I understand that it is my responsibility to update SEEAP with any insurance coverage changes. I understand I am responsible to pay for any services that my insurance policy deems as non-covered services.

_____ Self-pay Statement (if applicable): I understand that payment in full is expected at the time services is rendered.

_____ Financial Disclosure: I understand SEEAP accepts cash and credit card payments (including Health Savings Account credit cards). We do not accept checks. I guarantee payment for all services that are provided to my child.

_____ I understand that if I arrive more than 10 minutes late for my appointment, I may be asked to reschedule for another time or day. SEEAP reserves the right to charge a $25 fee for appointments cancelled within 2 hours or when a patient does not arrive for appointment.

_____ I understand that well child care is an important component of the healthcare of my child. I understand that these visits are what truly constitute preventative care and how we partner with you for optimal health and well-being for my child. We require children under 2 in our primary care practice be seen at 3-5 days, 2-4 weeks, 2, 4, 6, 9, 12, 15, and 18 months of age. Children over 2 years are seen at least annually. I understand that SEEAP reserves the right to terminate care if regular well child care is not maintained.

_____ I understand that SEEAP is not a walk-in clinic and that SEEAP makes every effort to see my child for same-day sick visits. I will call the office or utilize the portal to schedule appointments or request forms for my child.

_____ Supplement Transparency Statement – I understand that SEEAP practitioners may recommend supplements that may benefit the health of my child. I understand that supplements are not reviewed by the FDA as prescription medications are, and that supplements sold in our office or from our online account may provide revenue for SEEAP.

Signature of Parent/Guardian: ____ Date: _____________