Drs. Black & Benton Pediatrics
QUALITY CARE WITH CARE

Chart # _____

# Annual Adult (18+) Patient Registration Form

We are required to obtain complete updated information on each patient annually.

## Patient's Information

(Entire form to be filled out by the patient.)

| Full Name (First, Middle and Last) | | | DOB | Gender | Patient Phone # |
|---|---|---|---|---|---|
| | | | | M / F | |
| Race | Hispanic | Social Security # | Email Address | | |
| | Y / N | | | | |
| Mailing Address | | City | | State | Zip Code |
| | | | | | |
| Occupation | | Employer | | | |
| | | | | | |

Patient lives with: ___Both Parents ___Mother ___Father ___Other (please specify) _____

## Consent to Routine Medical Care

I understand and acknowledge that as of my 18th birthday, my parents and/or guardians will no longer be permitted access to my medical records, information, providers, or inquire about appointment status without my specific written permission.

Drs. Black and Benton, PSC will not release medical information to my parents without my written authorization in accordance with this document.

## Initial one:

___ **I DO NOT WISH TO** grant access to my parents / guardians. NO medical information, records, or appointment status information can be discussed or released. I will be responsible for all communications regarding my medical care including making appointments, calling the office nurse and picking up prescriptions or forms.

___ **I WISH TO** grant the following individuals access to my healthcare providers and/or medical information. (Please list all below.)

| First Name | Last Name | Phone # | Relationship to Patient |
|---|---|---|---|
| | | | |
| | | | |

## Emergency Contact Information

(Please list someone who is not the patient's parent/guardian and does not live with the patient.)

| Name | Relationship to Patient | Phone # |
|---|---|---|
| | | |

## Primary Insurance Information

| Insurance Company | Subscriber Name | Subscriber DOB | Relationship to Patient |
|---|---|---|---|
| | | | |
| Policy ID | Group # | Beg. Effective Date | Through an employer? |
| | | | Y / N |

## Secondary Insurance Information

| Insurance Company | Subscriber Name | Subscriber DOB | Relationship to Patient |
|---|---|---|---|
| | | | |
| Policy ID | Group # | Beg. Effective Date | Through an employer? |
| | | | Y / N |

## Courtesy Appointment Reminders should be sent to:

(Texting rates may apply; check with your carrier.)

| Name | Cell Phone # | Email Address |
|---|---|---|
| | | |

## Pharmacy Information

| Preferred Pharmacy | Location / Address | Phone Number |
|---|---|---|
| | | |

(Continued on other side ➔)

## Parent/Guardian Information

| First Name | MI | Last Name | DOB | Gender | Phone # |
|---|---|---|---|---|---|
| | | | | M / F | |

| Mailing Address (if different than patient) | City | State | Zip Code |
|---|---|---|---|
| | | | |

| Relationship to Patient | Marital Status | Social Security # | Occupation | Employer |
|---|---|---|---|---|
| | | | | |

## Other Parent/Guardian Information

| First Name | MI | Last Name | DOB | Gender | Phone # |
|---|---|---|---|---|---|
| | | | | M / F | |

| Mailing Address (if different than patient) | City | State | Zip Code |
|---|---|---|---|
| | | | |

| Relationship to Patient | Marital Status | Social Security # | Occupation | Employer |
|---|---|---|---|---|
| | | | | |

## Monthly Statements & Billing should be sent to:

| Name | Mailing Address (if different than patient) | City | State | Zip Code |
|---|---|---|---|---|
| | | | | |

| ☐ Check here if you prefer to receive billing statements by email. | Email Address |
|---|---|
| | |

### Financial Policy

Your insurance policy is a contract between the subscriber and the insurance company; Drs. Black & Benton, PSC are not a party to that contract. Insurance billing is filed by Drs. Black & Benton, PSC one time as a courtesy to the patient and guarantor. Parents/Guardians are financially responsible for all co-pays and deductibles. Parents/Guardians will be held responsible for the entire amount of the insurance claim if the correct insurance information is not provided to Drs. Black & Benton, PSC in a timely manner. It is the responsibility of the Parents/Guardians to ensure that the providers at Drs. Black and Benton, PSC are in network with the insurance policy. Full payment is expected at time of service if there is not sufficient insurance coverage for the services rendered. Both Parents/Guardians are responsible for any and all bills incurred, regardless of any divorce decree or court order stating otherwise.

Should a payment default on the account occur, an additional 40% of the defaulted amount will be added to the account for collection agency fees, and if necessary, additional court costs and attorney fees will also be added to the account. In the event this account is involved in litigation, objections to the venue are expressly waived. Set venue will be Knox County, Tennessee.

### Non-Covered Services Policy

The doctors at Drs. Black and Benton, PSC want to provide the best care possible to every patient. There may be services that the provider feels are necessary for the maintenance of good health that are not covered by the insurance contract. It is the responsibility of the Parents/Guardians to know what is covered by their insurance plan and address any concerns before services are rendered. Parents/Guardians will be expected to pay for all services rendered in full within three (3) months of date of service regardless of whether the insurance company has processed the claim.

### Copay & Coinsurance Amounts

Drs. Black & Benton does not determine how much your copay or coinsurance amounts are. This is determined by your insurance company. If you have questions or concerns regarding your copay or coinsurance amounts, you should contact your Plan Administrator.

### Missed Appointment Policy

Please contact our office no less than 24 hours prior to your scheduled appointment if you need to reschedule or cancel. Any missed appointments without 24 hour or more notice will be subject to a $25 fee which is charged to the patient and not to the insurance company. In addition, if three or more appointments are missed among all patients in a family within 365 consecutive days, the entire family is subject to dismissal from the practice.

### Notice of Privacy Practices Policy / HIPAA

Signing below indicates acknowledgement that a copy of the Notice of Privacy Practices Policy / HIPAA has been provided to you to review prior to signing.

Signing below also indicates that you have read and understand the financial and other policies of Drs. Black and Benton, PSC's as described above, and that your included answers on the front of this form are accurate and complete.

**Patient Signature** _____ **Date** _____

| Office Use Only | Entered By: | Entered Date: |
|---|---|---|