PATIENT REGISTRATION FORM

Desired Location ☐ Central Campus - 982 Eastern Parkway
☐ East Campus - 9810 Bluegrass Parkway

Patient Name ______________________________
First Middle Last

Date of Birth ______________________

Gender ☐ Male ☐ Female ☐

New Patient ☐ Yes ☐ No

What category best describes your race?

☐ American Indian or Alaska native
☐ African American
☐ Native Hawaiian or Other Pacific Islander
☐ Asian
☐ Caucasian
☐ Other ______________________

Do you consider yourself Hispanic or Latino? ☐ Yes ☐ No

PARENT AND GUARDIAN INFORMATION

Check one:

☐ Father
☐ Stepfather
☐ Guardian
☐ Mother
☐ Stepmother

____
First Middle Last

Date of Birth ______________________

☐ Married
☐ Single
☐ Divorced
☐ Custodial Parent
☐ Guardianship
☐ Joint Custody

Address ______________________
City ______________________
State ____________ Zip ________
Email ______________________
Home Phone ______________________
Cell Phone ______________________
Work Phone ______________________

Employer ______________________
Occupation ______________________

Check one:

☐ Father
☐ Stepfather
☐ Guardian
☐ Mother
☐ Stepmother

____
First Middle Last

Date of Birth ______________________

☐ Married
☐ Single
☐ Divorced
☐ Custodial Parent
☐ Guardianship
☐ Joint Custody

Address ______________________
City ______________________
State ____________ Zip ________
Email ______________________
Home Phone ______________________
Cell Phone ______________________
Work Phone ______________________

Employer ______________________
Occupation ______________________

Guarantor (person responsible for bill)

Name ____________________

Address ____________________

City/State/ZIP ____________________

Date of Birth ____________________

Emergency Contact Information

Name ____________________

Relationship to patient ____________________

Home Phone ____________________

Alternative Phone ____________________

Insurance Information (Primary)

Subscriber Name ____________________ Effective Date __________

Relationship to Patient ____________________ Group # __________

Insurance Company ____________________ ID # __________

Insurance Address ____________________ Insurance Phone __________

Insurance Information (Secondary)

Subscriber Name ____________________ Effective Date __________

Relationship to Patient ____________________ Group # __________

Insurance Company ____________________ ID # __________

Insurance Address ____________________ Insurance Phone __________

Referral Information

Primary Care Physician (full name) ____________________

Name of Practice ____________________ Phone __________

Referring Physician (if different than PCP) ____________________

Diagnoses 1) ____________________ 2) ____________________

Household Annual Income (Required) – Please check appropriate box:

- ☐ Under $20,000
- ☐ $20,000-$30,000
- ☐ $30,000-$40,000
- ☐ $40,000-$50,000
- ☐ $50,000-$60,000
- ☐ $60,000-$70,000
- ☐ $70,000-$80,000
- ☐ Over $80,000

Number of persons in household __________

This information is necessary for Kids Center to receive support from Metro United Way and other funders. If you wish to be considered for financial assistance from Kids Center, please contact Lisa Campbell or Pam Herthel at 502-635-6397. You will need to bring the first page of your most recent federal form 1040 to Kids Center (do not mail)

PATIENT FINANCIAL POLICY

Thank you for choosing Kids Center for Pediatric Therapies as your child's treatment service provider. We are committed to providing you with the best possible care. Your clear understanding of our financial policy is important to our agency/family relationship.

INSURANCE CONDITIONS

We must emphasize that, as medical care providers, our relationship is with you and not with your insurance company. We cannot accept the responsibility of negotiating the claims with insurance companies or any other persons. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date of the services rendered.

Your insurance coverage is a contract between you and your insurance company. It is very important that you understand the provisions of your policy. We cannot guarantee payment of claims. If your insurance company pays only a portion of the bill or rejects your claim, any contact or explanation should be made to you, their

policyholder. Reduction or rejection of your claim by your insurance company does not relieve you of your financial responsibility. Please remember that professional services are rendered and charged to the patient, not the insurance company.

FINANCIAL AGREEMENTS

I understand and agree that if any insurance company requires a referral from my primary care physician prior to receiving services at Kids Center, it is my responsibility to obtain the referral. Referrals and/or prescriptions may be faxed to Kids Center at

Central Campus: (502) 635-1147 East Campus: (502) 589-2409

Please initial here ___________

I authorize any payment of medical benefits to be paid directly to Kids Center. I authorize release of my medical information necessary to process my claim and secure payment.

Please initial here ___________

I understand and agree that I am financially responsible for all charges whether or not paid by my insurance company. I agree that I am responsible for any deductibles and co-pays are expected at time of service. I agree to keep my account current and to notify the billing department of any changes in my insurance coverage.

Please initial here ___________

If I cannot pay my balance, I agree to work out a payment plan by contacting the Chief Operating Officer or Book Keeper (502) 635-6397.

Please initial here ___________

PLEASE BE AWARE THAT FREQUENTLY IT TAKES SOME TIME FOR CLAIMS TO BE RECONCILED BY YOUR INSURANCE COMPANY. THIS CREATES THE POSSIBILITY THAT A LARGE PATIENT OWED BALANCE CAN ACCRUE BEFORE YOU RECEIVE YOUR STATEMENT FROM KIDS CENTER. WE ENCOURAGE YOU TO UNDERSTAND WHAT YOUR LIABILITY FOR SERVICES COULD BE ACCORDING TO YOUR SPECIFIC POLICY COVERAGE. OUR BILLING MANAGER IS AVAILABLE BY APPOINTMENT TO GO OVER THIS WITH YOU.

Signature of Parent or Guardian ______________________________ Date Signed ____________