Ptarmigan Pediatrics | Ptarmigan Connections

3543 E Meridian Park Lp, Ste A
Wasilla, AK 99654
**Phone:** (907) 357-4KID (4543)
**Fax:** (907) 357-4533
ptarmiganpediatrics.com

3505 E Meridian Park Lp, Ste 200
Wasilla, AK 99654
**Phone:** (907) 357-4400
**Fax:** (907) 357-4410
ptarmiganconnections.com

# *Patient Registration Form*

## Mother ☐Bio-mother ☐Stepmother ☐Guardian ☐Other:_____

**Full Name**_____ **SSN** _____ **DOB** _____

**Mailing Address** _____ **Zip code** _____

**Physical Address** _____ **Zip code** _____

**Home/Work (circle one) Phone** _____ **Cell Phone** _____

**Email:** _____**Preferred Contact Method: ☐ Home Phone☐ Cell Phone☐ Work Phone**

## Father ☐Bio-father ☐Stepfather ☐Guardian ☐Other:_____

**Full Name**_____ **SSN** _____ **DOB** _____

**Mailing Address (if different than above)** _____ Zip code _____

**Physical Address** _____ Zip code _____

**Home/Work (circle one) Phone** _____ **Cell Phone** _____

**Email:** _____**Preferred Contact Method: ☐ Home Phone☐ Cell Phone☐ Work Phone**

**Preferred Pharmacy** _____

**Family's Preferred Language** (although we cannot guarantee we can communicate with you!)**:** ☐ English | ☐ Other: _____

***** INSURANCE INFO** (present card(s) to front desk) **☐ Self Pay** ****THIS SECTION MUST BE FILLED OUT****

**Primary** Insurance Company:_____ Policy#:_____ Group#:_____

Policy Holder's Name: _____SSN: _____ DOB: _____

**Secondary** Insurance Company: _____Policy#:_____ Group#:_____

Policy Holder's Name: _____SSN: _____ DOB: _____

**1. Child's Full Name** _____ **Date of Birth** _____ **Gender:** ☐ M ☐ F

**Primary Race:** ☐ African American, ☐ Alaska Native, ☐ American Indian, ☐ Asian, ☐ Caucasian, ☐ Hispanic, ☐ Pacific Islander

**Ethnicity:** ☐American, ☐ Inuit/Eskimo, ☐ Canadian, ☐ Russian, ☐ Ukrainian, ☐ Iraqi, ☐ Other: _____

**2. Child's Full Name** _____ **Date of Birth** _____ **Gender:** ☐ M ☐ F

**Primary Race:** ☐ African American, ☐ Alaska Native, ☐ American Indian, ☐ Asian, ☐ Caucasian, ☐ Hispanic, ☐ Pacific Islander

**Ethnicity:** ☐American, ☐ Inuit/Eskimo, ☐ Canadian, ☐ Russian, ☐ Ukrainian, ☐ Iraqi, ☐ Other: _____

**3. Child's Full Name** _____ **Date of Birth** _____ **Gender:** ☐ M ☐ F

**Primary Race:** ☐ African American, ☐ Alaska Native, ☐ American Indian, ☐ Asian, ☐ Caucasian, ☐ Hispanic, ☐ Pacific Islander

**Ethnicity:** ☐American, ☐ Inuit/Eskimo, ☐ Canadian, ☐ Russian, ☐ Ukrainian, ☐ Iraqi, ☐ Other: _____

**4. Child's Full Name** _____ **Date of Birth** _____ **Gender:** ☐ M ☐ F

**Primary Race:** ☐ African American, ☐ Alaska Native, ☐ American Indian, ☐ Asian, ☐ Caucasian, ☐ Hispanic, ☐ Pacific Islander

**Ethnicity:** ☐American, ☐ Inuit/Eskimo, ☐ Canadian, ☐ Russian, ☐ Ukrainian, ☐ Iraqi, ☐ Other: _____

****** If you have more than 4 children, please see the front desk for an additional page******

★ ***Signature of parent or legal guardian*: _____ *Date:*** _____

***Printed name of Parent of Legal Guardian:*** _____

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# *HIPAA Acknowledgement, Office Policies, Assignment of Benefits*

*If you are submitting this remotely, please mail/fax this completed form with a copy of Insurance & ID card(s) to the address at the top of this page.

By signing below, I, _____, hereby…
(Printed name of parent or legal guardian)

1. …acknowledge **receipt of or access to Ptarmigan Pediatrics / Ptarmigan Connections, HIPAA / Privacy Notice** and recognize that changes to this policy may occur at any time without notice. I will always have access to the most recent Notice at the clinic website: *www.ptarmiganpediatrics.com* / *www.ptarmiganconnections.com*, or posted in the clinic office waiting room. **I may request a written copy at any time**.

2. …believe that Ptarmigan Pediatrics / Ptarmigan Connections, is **committed to providing the highest quality medical care** for my family members aged birth through 17 years.

3. …commit to **canceling appointments** with as much notice as possible, and understand that failure to notify this office of my inability to keep any appointment will result in a "no-show." Repeated no-shows are serious and may involve a fine which must be paid prior to the child being seen again in this clinic, acceptance at the clinic on a walk-in basis only (as time allows), or both. Insurances do NOT cover no-show charges. Patients **over 15 minutes tardy** may be asked to reschedule.

4. …understand that Ptarmigan Pediatrics / Ptarmigan Connections is proud to be a **mentoring / training facility** for students in health related fields, who may provide care to my child under the supervision of the licensed clinical staff.

5. …agree that **my child cannot be seen in this clinic without a parent or legal guardian** (or my representative designated in writing) being present. "Guardianship agreement" forms are available in our office or via download on our website.

6. …authorize Ptarmigan Pediatrics / Ptarmigan Connections, to **submit claims to my child's insurance company(s)** on my child's behalf, and my child's insurance company(s) to pay benefits directly to Ptarmigan Pediatrics / Ptarmigan Connections.

7. …understand that should any insurance payment be made directly to me for monies due on this account, I agree to immediately pay over these funds to Ptarmigan Pediatrics / Ptarmigan Connections.

8. …understand that **an "out-of-network" insurance carrier may limit payments** for any or all services provided by Ptarmigan Pediatrics / Ptarmigan Connections, regardless of the advertised benefits package. (i.e., they may pay less than our standard charges, even if they advertise "100% benefit").

9. …agree that upon acceptance of services provided by Ptarmigan Pediatrics / Ptarmigan Connections, **I assume responsibility for any deductible, co-pay and coinsurance, *as well as any other balance not covered by my child's insurance carrier*. Copays and estimated coinsurances are due at the time of service.** If my account is turned over to **Cornerstone Credit Services** for collections**, I agree to pay any resulting collection and legal fees**.

10. Furthermore, I understand that if I personally pay all billed charges in full at the time of service, I am eligible for **"prompt-pay/self-pay discount."**

**Name(s) of Children / Patients**: _____

**Printed Name of Parent or Legal Guardian:** _____

**Signature of Parent or Legal Guardian:** _____ **Date:** _____



A photocopy of this assignment is considered to be as valid as the original.