

11050 Crabapple Road
Suite 120
Roswell, GA 30075
(770) 518-9277
(770) 518-8718 fax

1111 Alderman Drive
Suite 250
Alpharetta, GA 30005
(678) 527-1555
(678) 527-1559 fax



**Pediatric
Physicians,
PC**

**Parent
Registration**

PPPC Account # _____

Your kindness in furnishing the following information will be appreciated. The information will be used in strict confidence to prepare your chart.

Your full name: _____ Male: _____ Female: _____

Birth date: _____ SS # _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home phone: _____ Mobile phone: _____ Business phone: _____

Who carries the Insurance? _____

Who is responsible for medical bills? _____

If your spouse carries your insurance or is responsible for your medical bills, please provide the following information:

Spouse's full name: _____ Birth date: _____ SS#: _____

Address (if not the same): _____

City: _____ State: _____ Zip Code: _____

Home phone: _____ Mobile phone: _____ Business phone: _____

- Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.
- **IN ORDER TO CONTROL YOUR COST OF BILLINGS, WE REQUEST THAT OUR CHARGES FOR OFFICE VISITS BE PAID AT THE CONCLUSION OF EACH VISIT.**
- If this account is assigned for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection.
- To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's records.
- I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance and other health plans to **Pediatric Physicians, PC.**
- This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.
- I have been given the opportunity to review the Notice of Privacy Practices for **Pediatric Physicians, PC.**

SIGNED _____ DATE _____