After Hour Pediatrics Urgent Care Clinic
PATIENT REGISTRATION

Patient Name: _____, _____ _____ **Date of Birth** _____ **Gender M / F**
(Last) (First) (M.I.)
Patient lives with: Mother Father Both Parents Self Guardian Other _____

Sibling names:_____

Insurance Subscriber:
Name:_____

Email: _____

Date of Birth _____

Address _____

City _____ State _____Zip_____

Home _____ _____ _____

Work _____ _____ _____

Cell _____ _____ _____
Preferred contact: Home Work Cell E-mail
Primary Insurance? Yes No I don't know
Send bill to this address? Yes No

Parent #2 _____

Email: _____

Date of Birth _____

Address_____

City_____ State _____Zip_____

Home _____ _____ _____

Work _____ _____ _____

Cell _____ _____ _____
Preferred contact: Home Work Cell E-mail
Secondary Insurance? Yes No I don't know
Send bill to this address? Yes No

Patient's Primary Physician_____

How did you learn about After Hour Pediatrics? Pediatrician Friend Yelp Google Other_____

<u>After Hour Pediatrics is currently a contracted provider for:</u>
***Mills Peninsula Medical Group HMO plans *Sequoia Physicians Network HMO plans *Palo Alto Mills Peninsula Division HMO Plans* Sutter Select/UMR*Aetna PPO *Cigna PPO *Blue Cross PPO *Blue Shield PPO and Blue Shield Direct HMO plans *Great West * United Healthcare PPO. * Healthnet PPO**

We only bill primary insurance. AHP does not bill out-of-network providers. Please review the Credit Card Release authorization.

<u>If your insurance does not appear on the list above, After Hour Pediatrics is an out-of-network provider for your plan**</u>**
Payment in full at the time of service is required. You will be given a receipt and claim form to submit as needed.

--CONSENT--

Y / N I certify that the above information is true and I consent to any medical or surgical treatment rendered the patient under the general or special instructions of the physician.

Y / N I may review in detail After Hour Pediatrics' Privacy Practices and may request special privacy considerations.

Y / N I understand the above insurance billing and payment information, and hereby accept responsibility for all charges related to this treatment, including any charges which are not covered by insurance.

I would like and hereby authorize AHP to send messages to me via my email, which may be non-secure, and/or to leave telephone messages about:

Y / N Billing and insurance matters

Y / N Medical information, such as lab and X-Ray results and follow-up.

_____ _____ _____
Date **Signature of Credit Card holder** **Name of Credit Card Holder**