

New Patient Registration

Patient Name:

DOB:

Address:

City: State: Zip:

Please select the correct box with an X

Sex: M : F

Race: American Indian/ Alaska Native : Asian :

African American / Black : Caucasian / White :

Hispanic : Native Hawaiian / Other Pacific Islander :

Other :

Primary Language

Primary Contact Number:

Secondary Contact Number

Previous PCP:

PCP Phone:

PCP Fax: □□□-□□□-□□□□

How did you hear about us? Online : Friends/Family :

Other : □□□□□□□□□□□□□□□□□□□□□□□□

Which Location Will You Be Visiting? Williams Road :

Barnesville : Thomaston : 13th Street

Does the patient have siblings that are patients here?

Yes : No :

Siblings Name: □□□□□□□□□□□□□□□□□□□□□□□□

Parent Information

Mothers Name : □□□□□□□□□□□□□□□□□□□□□□□□

SSN: □□□□□□□□□□ DOB: □□/□□/□□□□

Address: □□□□□□□□□□□□□□□□□□□□□□□□□□□□

City: □□□□□□□□□□□□□□□□ Zip: □□□□□

Phone: □□□-□□□-□□□□ Work: □□□-□□□-□□□□

Employer: □□□□□□□□□□□□□□□□□□□□

Father's Name: □□□□□□□□□□□□□□□□□□□□□□□□

SSN: □□□□□□□□□□ DOB: □□/□□/□□□□

Address: □□□□□□□□□□□□□□□□□□□□□□□□□□□□

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Phone: □□□-□□□-□□□□ Work: □□□-□□□-□□□□

Employer: □□□□□□□□□□□□□□□□□□□□

Emergency Contact Name:

□□□□□□□□□□□□□□□□□□□□□□□□□□

Phone: □□□-□□□-□□□□

Relationship to patient: □□□□□□□□□□□□□□

Pharmacy Name: □□□□□□□□□□□□□□□□□□□□

Location: □□□□□□□□□□□□□□□□□□□□

Patient Portal Communication

: YES, I want Zoe pediatrics to communicate my children's information with me through a secure patient portal system that is designed to keep medical information safe. You will be notified by email when these is secure information for you to review. The email will provide a link that will take you to your patient portal. After clicking the link, you will be required to log in and enter a password to access your information.

: No, I do not want Zoe pediatrics to use electronic communication as a way to communicate my children's

information to me. I understand that copies of lab results, physician statements, and shot records I request to be printed, faxed, may incur a fee.

Email:

Insurance Information

Policy Holder Name:

Insurance Company:

Address:

Phone: -- Effective Date: --

Subscriber Number:

Group Number:

Secondary Insurance

Policy Holder Name:

Insurance Company:

Address:

Phone: -- Effective Date: --

Subscriber Number:

Group Number:

Financial Responsibility for Services Rendered by ZÖe Pediatrics Physicians

I acknowledge that acceptance of my insurance information is not a guarantee of payment by my health plan until the claim has been processed and paid. I further understand that if my claim is not accepted for payment, I am personally responsible for payment of medical services rendered to myself or a member of my family.

I acknowledge that medical billing statements for services rendered by ZÖe Pediatrics Physicians will be sent to the person who carries the insurance for the patient/family member.

- I understand that I am responsible for the accuracy of the information I have provided on this form.
- I authorize payment of medical benefits to be made directly to ZÖe Pediatrics.
- I authorize the release of medical records necessary to process insurance claims.
- I authorize the release of correspondence and/or medical records to payers involved in my child’s care.
- I have read and understand the Financial Policy.

Name:

Signature: _____

Date: --

Self : Parent : Legal Guardian : Please check “X” one.

LATE TO APPOINTMENT POLICY

We value your time and strive to see you as close to your appointment time as possible. Recognizing unanticipated things happen, we will hold your appointment for a 15-minute grace period after the scheduled start time of your appointment. In consideration of every patient, all appointments will be automatically canceled thereafter. If you arrive after your appointment has been cancelled, you will be asked to either reschedule the appointment or wait to be seen as a ‘Walk-In’ patient.

Cell Phone Authorization : I hereby authorize Zoe Pediatrics to leave a message regarding appointments or tests at my residence or cell phone.

Yes : No

Authorization To Send Appointment Reminders : I hereby authorize Zoe Pediatrics to send appointment reminders or other alerts via txt message or automated voice message.

Yes : No

Photo Consent: I hereby authorize Zoe Pediatrics to take my picture for my electronic medical record.

Yes : No

No Show Policy:

The policy of Zoe Pediatrics is to monitor and manage missed appointments. This is necessary to ensure that we can provide timely access to care for all patients with our providers.

Scheduled appointments must be canceled or rescheduled at least 24 hours before the appointment time. Any patient who does not arrive for a scheduled appointment and does not cancel before the scheduled time will be considered a “no-show.” A \$50 no-show fee will be added to your account. Insurance does not cover no-show fees; this responsibility will fall to the guarantor.

After an established patient has three no-shows for Well Child Check appointments within a six-month period, they will no longer be allowed to schedule appointments and will instead be seen on a walk-in basis only.

Patients who wish to establish care with Zoe Pediatrics and do not cancel or reschedule their initial appointment at least 24 hours prior to the scheduled time will also be considered no-shows. On the third occurrence of missing their initial appointment, the patient will be denied entry into the practice. Patients will receive a discharge letter if they miss appointments after receiving text message communication.

If appointments are missed for multiple children, the family will not be allowed to schedule multiple-child appointments for six months.

If repeated no-shows continue after six months, the patient and all family members under the guarantor’s account may be discharged from the practice and asked to seek medical care with another provider.

We value you as a patient and recognize the challenges of coordinating all the demands on your time. We sincerely hope that you will notify us if you are unable to attend your appointment. This helps ensure that appointment times are fully utilized for patients with urgent needs.

We understand that unavoidable emergencies sometimes occur at the last minute. If a true emergency arises and you call us at your earliest opportunity to explain the situation, we will work with you to reschedule, and the no-show will not be counted against you.

If you have any questions, please contact our office at 706-641-2462.

Thank you for your understanding and support.

Have you read and understood the no show policy?

Yes : No

