

King Pediatric Clinic  
 13975 Connecticut Avenue - Suite 316  
 Silver Spring, MD 20906  
 Telephone (301) 438-0708

Please Print

## Patient Registration

Date				
First Name	Middle Initial	Last Name	Date of Birth	Gender __ Male __ Female
Social Security Number	Home Phone Number	Work Phone Number	Cell Phone Number	
Home Address		City	State	Zip
Marital Status __ Married __ Single __ Divorced __ Widowed		Home E-mail Address		
Employer/School		Work E-mail Address		
Employer Address		City	State	Zip

## Emergency Contact (Family or Relative)

Name	Relationship	Emergency Phone Number	
Home Address	City	State	Zip

## Insurance Information

Primary Insurance Company	Effective Date	Identification/Policy Number	
Insurance Address		Group Number	
City	State	Zip	Insurance Phone Number for Eligibility/Verification

Policy Holder/Subscriber's Name	Social Security Number of Subscriber	Co-Payment
Policy Holder/Subscriber's Employer	Gender __ Male __ Female	Birth Date of Subscriber

I certify that the information I have reported above is correct and that as the patient/guarantor I have read, understand, and fully accept the terms and conditions of registration as stated on this document.

\_\_\_\_\_  
Signature of Patient/Guarantor

\_\_\_\_\_  
Date

## Conditions of Registration

### THE PRACTICE

Bonita J. Harrison, MD, PC, currently d.b.a. King Pediatric Clinic, employees, agents, or assignees be referred to as The Practice.

### CONSENT FOR TREATMENT

The undersigned hereby consents to the administration of such medical treatment diagnostic and/or therapeutic procedures as required by the physician rendering care. Their procedures may include, but are not limited to, laboratory and x-ray procedures.

### HTV/HEPATITIS B & C VIRUSES TESTING NOTIFICATION

In accordance with Maryland law, any patient whose bodily fluids a healthcare worker has been exposed will be deemed to have consented to HIV/HEPATITIS B & C TESTING. In all other cases, the patient shall have the right to informed consent or referral for HIV/HEPATITIS B & C. We do not randomly test for HIV.

### AUTHORIZATION & ASSIGNMENT OF INSURANCE BENEFITS

I do hereby authorize The Practice to apply for benefits for services rendered to myself(us) under the health providing benefits and do hereby also assign and authorize payment of benefits from my insurance company to The Practice (including benefits payable under Title XVIII of the Social Security Act and /or any other governmental agency.) I irrevocably authorize all such payments to The Practice.

### RELEASE OF MEDICAL INFORMATION

I authorize The Practice to release any and all of my medical records and/or other information

and records required by my (our) insurance company or its designated review agents who provide insurance benefits in my (our) behalf, including if applicable, my employer and/or employer's workman's compensation insurance company, me Social Security Administration, or the Health Care Financing Administration, needed to determine benefits and to process insurance claims and secure payment of benefits to either the insured or to The Practice: and authorize any hospital, lab, physician, or other healthcare provider and/or their staffs to release my (our) medical records and/or other records and information on myself (us) to The Practice. I agree to pay any applicable charges for having my (our) records copied and transferred to another Primary Care Physician or to myself (us). Such charges not to exceed .50 cents per page for the first 50 pages and 25 cents per page thereafter in addition to a \$10.00 postage/handling fee.

#### REFERRALS & PRE-CERTIFICATIONS REQUIREMENTS

I hereby take full responsibility for all referrals and pre-certifications requirements as described or requested by my (our) insurance company. I understand it is my (our) duty and responsibility to contact the insurance company to make certain that the specialists, healthcare provider and/or health care facilities I am referred to are in network and that I have the appropriate paperwork or authorization prior to seeing a specialist healthcare provider or go to a healthcare facility. I further understand that if I must go to an emergency room or urgent care center I must notify The Practice prior to going if possible, or within 48 hours of that visit or in accordance with my insurance company's requirements. If any of the aforementioned procedures are not done and cause reduced or rejected coverage. I will take full responsibility in payment of all balances due. I authorize The Practice to contact my employer or insurance company regarding existence and coverage of my (our) insurance benefits.

#### FINANCIAL AGREEMENT

I agree that payment in full is due at the time of treatment. I the undersigned (jointly and severally if more than one) further agree that I am responsible and do hereby guarantee payment for any charges incurred. I also understand that I (we) may be billed separately for services rendered by other professionals including, but not limited to other physicians, radiologists, and laboratory work as appropriate and in accordance with the services rendered. Any questions or disputes concerning insurance coverage or payment of benefits is a matter between the insurance subscriber/policyholder and the insurance company. Should any balance arise due to insurance co-payments, co-insurance, deductible, termination of coverage, non-selection of a primary care physician (PCP), not adding a dependent to insurance plan, non-payment at time of service or a \$25.00 returned check fee. If balance is not paid within the 30 days or if agreed upon payment arrangements on this account are not made, I authorize the practice to retain the services of an attorney and/or collection agency to assist with the collection of any outstanding balance and that this action will be reported to credit bureaus and may affect my (our) credit rating. COPY OF SIGNATURE I permit a copy of this authorization and signature to be used in place of the original on all insurance claim submissions and for the release of any medical records and/or other records and information, as stated herein, whether manual, electronic or telephonic.

#### CERTIFICATION

I certify that the information I have reported with regard to my (our) insurance coverage is correct and that the above be honored by my (our) insurance carriers. This certification will also apply to application for benefits under Title XVIII of the Social Security Act and /or any other

governmental agency, if applicable. I also certify that I have read the forgoing and as the patient/guarantor understand and fully accept file terms therein.