

CENTER FOR COUGH

MANDEL SHER, M.D.

Minor Registration Form

Patient Name: _____ Age: _____ Birthday: _____ Sex: M F
Address: _____ City: _____ St. _____ Zip Code: _____
Home Phone: _____ School Attending: _____ Social Security#: _____

PARENT/GUARDIAN INFORMATION:

Mother: _____ Cell #: _____ E-mail: _____
Address(If different from above): _____ Home phone : _____
Employer: _____ Occupation: _____ Work phone: _____
Father: _____ Cell#: _____ E-mail: _____
Address(If different from above): _____ Home phone: _____
Employer: _____ Occupation: _____ Work phone: _____

PRIMARY INSURANCE INFORMATION:

Insurance Co: _____ Phone : _____
Mailing Address: _____
Name of Insured: _____ Birthday: _____ Relationship to Patient: _____
Policy # _____ Group# _____ Employer: _____

Secondary Insurance Information: Do you have other insurance coverage? Yes () No ()

Insurance Co: _____ Phone : _____
Mailing Address: _____
Name of Insured: _____ Birthday: _____ Relationship to Patient: _____
Policy # _____ Group# _____ Employer: _____

Other Misc. information:

Referred by: * Doctor() *Family() *Friend() Phone Book() Insurance Book() Internet Search() Other() _____
*Please give name & address: _____
Family Physician(PCP) _____ Phone: _____
Do you have other family members who are or have been patients in our office? _____ Relationship _____

FINANCIAL RESPONSIBILITY, ASSIGNMENT OF BENEFITS, AND RELEASE OF PROTECTED HEALTH INFORMATION

- I hereby agree to pay **CENTER FOR COUGH** for all charges (to include co-pays, deductible and co-insurance amounts) at the time of service. I understand that although the office may accept assignment of insurance benefits, the charges ultimately are my responsibility. I realize that if a balance is due necessitating the use of a collection agency, I agree to pay all collection costs, including attorney fees.
- I authorize **CENTER FOR COUGH** to file insurance claims on my behalf to the companies with which I have coverage to include the Social Security Administration. I authorize payment to be made to **CENTER FOR COUGH** for services rendered.
- I consent to the release of protected health information which may be necessary to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law.
- I acknowledge that I have received a copy of Health Insurance Portability & Accountability Act (HIPAA) Notice of Privacy Practices.
- I certify that I: **(Print Name)** _____ am the parent or legal guardian of the above named minor.

Parent/Guardian signature: _____ Date: _____