Optimum
Internal Medicine & Pediatrics

Adult and Pediatric Patient Registration form

We have your original registration forms on file, but we need to update your information in our system to make sure all information is still accurate.

Patient's Full Name	Date of Birth Social Security Number
Patient's Address	Telephone (Home) (Cell)
City State Zip	Email address

For Pediatric Patient's (Patient's under 18)

Mother's Name	Father's Name
Mother's Date of Birth Social Security Number	Father's Date of Birth Social Security Number
Mother's Address (if different from above)	Father's Address (if different from above)
Are there any custody issues to be noted?	

Current Pharmacy: _____

In case of an emergency, please list whom you would like us to contact:

Name: _____ Phone: _____

Disclosure of Medical Information

If you would like your medical information released to your spouse, children, care giver, etc., please list their name, relationship, and phone number for each individual.

Name:	Relationship:	Phone Number:
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____

Signature of Patient or Guardian **Print Name of Patient or Guardian**

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I attest to the validity of the information stated above. I attest that the information I have given is true, accurate, and complete to the best of my knowledge. I understand that knowingly giving false information will result in termination of care by Optimum Internal Medicine & Pediatrics and possibly result in criminal prosecution for falsifying information. I agree to inform you of changes in my insurance status, address, phone, or other demographic information as it occurs. I understand that I may be asked to fill out this form again even if my situation has not changed.
I understand that if the insurance information I have given is not accurate and/ or my plan does not cover the cost of my visit, I will be responsible for paying the entire amount of my healthcare costs received during my patient visits. **Medical Consent** I consent to all treatment given under the general and special instructions of the attending provider and/or his designee. Treatment may include, but not limited to, diagnostic procedures, therapeutic procedures, administration of anesthetics, use of prescribed medication, medical services, the collection and utilization of cultures and laboratory specimens, referral to specialty services for radiology, physicians consultation, and other medical services, all of which may be considered medically necessary or advisable in the judgment of the attending physicians or their designees. I realize that certain unforeseen risks are inherent with medical treatment and no medical provider can guarantee a specific outcome, cure, diagnosis, or result but Optimum Internal Medicine and Pediatrics pledges to provide care consistent with professional standards. I authorize Optimum Internal Medicine and Pediatrics to release any health information to my insurance company or other payer, for the purposes of payment for any services provided. I also authorize Optimum Internal Medicine and Pediatrics to provide health information to other physicians and healthcare facilities for any continuing care. I also acknowledge that I have been informed and am able to receive a copy of the Notice of Privacy Practices for Optimum Internal Medicine & Pediatrics at any time. **Payment of Services** I authorize the release of any medical information necessary to process Insurance claims for my medical benefits. I authorize and assign any payment of medical benefits to Optimum Internal Medicine and Pediatrics, its successors and assigns, or any individual it may designate for the services provided. Our office will inform you of the amount due when you check out. This includes, but not limited to, Co-Payment, deductibles, etc. This amount is due at the time of service. As a courtesy to you, we will file your insurance claims if you provide us with a copy of your current insurance card. I understand that if I am self-funded or sliding fee, full payment is due at the time of service. I further agree to pay all costs of collection, including attorney's fees, collection agency fees, and any other fees associated with the collection of any amount due for services rendered and performed. I understand that I am financially responsible for Optimum Internal Medicine and Pediatrics, its successors and assigns and any individual it may designate for any balance not covered by insurance. If you are having laboratory and/ or diagnostic services by providers other than Optimum Internal Medicine and Pediatrics, you may be billed separately by the lab or diagnostic facility providing the service. I understand that Optimum Internal Medicine and Pediatrics has a sliding fee schedule and if I am eligible, I will honor and abide by the financial rules for sliding fee patients. I also understand that this sliding fee schedule is voluntarily offered by Optimum Internal Medicine and Pediatrics to offer medical care for those that have fallen on difficult financial times. *A $35.00 service charge will be added on all returned checks******Delinquent accounts may be forwarded to a collection agency. **No Call/No Show Policy**: Our office asks that you make every scheduled appointment. We, however, understand that missed appointments do occasionally occur. We ask that you call at least 24 hours before your scheduled appointment to cancel. If you are unable to call and cancel and you miss your appointment a $35 charge will be added to your account as a "No Cancellation Fee **Assignment of Insurance Benefits and Third party Claims**: If the account is not paid at the time of service, I hereby assign to Optimum Internal Medicine and Pediatrics the proceeds from the following: TRICARE medical benefits; PIP (personal injury protection); sick benefits; physician benefits; injury benefits; any health or accident benefits of any form relating to the patient, whether insured or self-funded; proceeds of any liability settlement or judgment being paid by a third party; and any other benefits due from my insurance policy. All amounts collected will be applied to the patient's account. I understand that I am responsible for any charges not covered by insurance or other benefits and I agree to pay any fees due in full for services rendered. I further warrant and represent that any insurance or any plan that I assign is valid insurance. In the event a claim for payment submitted by Optimum Internal Medicine and Pediatrics to my insurance carrier or plan administrator is denied, I hereby authorize Optimum Internal Medicine and Pediatrics to seek an administrative review of the disputed claim in accordance with the applicable provision(s) of my plan or policy. If this review is denied or the insurance company refuses payment for any reason, I understand and accept that I am still responsible and will pay in full for all services rendered.
My signature also authorizes my primary care provider to electronically communicate medical information with other treating providers as part of the care coordination involved in these services. I also allow the utilization of AI products such as ambient AI in my or my child's care with my health information protected via HIPAA compliant means at all times. I also understand that if my child or I am eligible for Advanced Primary Care, Chronic Care Management, Remote Patient Monitoring, Electronic care services, Tele-health Services, and any service my provider deems appropriate for my child or I that my signature serves as enrollment in these services and I consent to these services and understand there may be associated co-payments, deductibles, or fees that apply and I can cancel these services at any time effective at the end of the current month by notifying my provider and revoking these services per protocol.

_____

Signature of Patient / Guardian

_____

Date Signed

_____

Print Name of Patient

_____

Patient Date of Birth