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13050 Parkside Drive
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Fishers, Indiana 46037
(317) 621-9000

New Patient Registration Packet

Thank you for choosing Northpoint Pediatrics for the care of your child. In an effort to save you time at your first appointment, we have put together a packet of paperwork that we need to collect from you on your first visit.

Please complete the following forms and bring them with you to your first appointment:

- **Northpoint Pediatrics patient Registration Form**
- **Northpoint Pediatrics Signature Sheet**
- **Insurance policy Holder Information Sheet**

Please be prepared with your insurance card(s) at each appointment. Our staff will scan a copy of your insurance card into your child's chart at each appointment.

Our website provides a wealth of information ranging from printable forms, health information, financial information, provider profiles, and communication resources.

A copy of Northpoint Pediatrics' Notice of Privacy Practices can be printed from our website at www.northpointpeds.com under the forms tab.

Please visit our financial tab on our website for questions on insurance, payment, coding, and billing policies. If you have questions on what will be covered by insurance for services received in our office, please utilize our Benefit Verification Form when calling your insurance company. This form can be found under the forms tab on the main page of our website.

Please let us know if we can assist you and your family in any way. We would like to take this opportunity to thank you for allowing us to care for your family.

Northpoint Pediatrics

Northpoint Pediatrics Patient Registration Form

Patient's Full Name			Acct#
Date of Birth	BOY <input type="checkbox"/>	GIRL <input type="checkbox"/>	PCP
Patient's Full Name			Acct#
Date of Birth	BOY <input type="checkbox"/>	GIRL <input type="checkbox"/>	PCP
Patient's Full Name			Acct#
Date of Birth	BOY <input type="checkbox"/>	GIRL <input type="checkbox"/>	PCP
Patient's Full Name			Acct#
Date of Birth	BOY <input type="checkbox"/>	GIRL <input type="checkbox"/>	PCP

PLEASE CIRCLE ONE - Children live with both parents, mother, father, other - please list _____

Father's Name / Domestic Partner - circle one		Mother's Name / Domestic Partner - circle one	
SSN	Date of Birth	SSN	Date of Birth
Street Address		Street Address	
City, State, Zip		City, State, Zip	
Employer		Employer	
Home Phone	Work Phone	Home Phone	Work Phone
Cell Phone	Pager	Cell Phone	Pager

Insurance Policy Holder's Name		Relationship to child	
Step Mother's Name / Domestic Partner - circle one		Step Father's Name / Domestic Partner - circle one	
SSN	Date of Birth	SSN	Date of Birth
Street Address		Street Address	
City, State, Zip		City, State, Zip	
Employer		Employer	
Home Phone	Work Phone	Home Phone	Work Phone
Cell Phone	Pager	Cell Phone	Pager

Parental Relationship - please circle one - Married Separated Divorced Never Married Widowed

LEGAL PARENT / LEGAL GUARDIAN SIGNATURE	PRINTED NAME	DATE

Today's Date	Form received/completed by:	Entered by:	Scanned by:

Northpoint Pediatrics

****PLEASE READ AND INITIAL EACH SECTION AND SIGN AT THE BOTTOM****

Office use only

Child's Name: _____	DOB: _____	Acct #: _____
Child's Name: _____	DOB: _____	Acct #: _____
Child's Name: _____	DOB: _____	Acct #: _____
Child's Name: _____	DOB: _____	Acct #: _____

CONSENT FOR MEDICAL TREATMENT OF A MINOR

I (we) the undersigned legal parent(s) or guardians of stated child(ren), a minor(s), do hereby authorize and consent to any medical exam or treatment rendered under the general or special supervision of any Northpoint Pediatric Physician or Nurse Practitioner, a duly licensed physician or nurse practitioner, licensed under the provisions of the laws in the State of Indiana. It is understood that this authorization is given in advance of any specific diagnosis, recommended treatment or recommended medical care being required but is given to provide authority and power to render care, which the aforementioned physician or nurse practitioner in the exercise of his or her best judgment may deem advisable.

Restrictions: _____

_____ initials

FINANCIAL RESPONSIBILITY AGREEMENT

I have received, read and agree to adhere to the Northpoint Pediatrics's Financial Responsibility Agreement Version 2.3.

_____ initials

NOTICE OF PRIVACY PRACTICE

I have received and read the Northpoint Pediatric Notice of Privacy Practice.
A copy of the Notice of Privacy Practice may be printed from our website.

_____ initials

CONSENT FOR COMMUNICATION VIA ELECTRONIC MAIL

I have read and agree to the Northpoint Pediatric consent for communication via electronic mail.
Email communication is initiated by parent to Patient Account Department to answer account questions.

_____ initials

Email address _____

Legal Parent / Legal Guardian Signature: _____

Printed Name: _____

Relationship to Child: _____ Today's Date: _____

****Office Use Only – Form scanned by _____ Date Scanned _____**
Form entered by _____ Date entered _____
Form received by _____

		Today's Date:		Office Use Only		
To be completed by parent:	Child's Name:		DOB:		Office Use Only	
	Child's Name:		DOB:			Acct #:
	Child's Name:		DOB:			Acct #:
	Child's Name:		DOB:			Acct #:
	Child's Name:		DOB:		Acct #:	
	DOES EACH CHILD HAVE THEIR <u>OWN INSURANCE CARD</u> OR IS THERE A <u>FAMILY CARD</u> ? Please circle one					
	POLICYHOLDER INFORMATION:					
	Name of PRIMARY INSURANCE:			(if applicable) SECONDARY INSURANCE:		Name of
	Effective Date:			Effective Date:		
	Policyholder:		M / F	Policyholder:		M / F
DOB:	SS #		DOB:	SS #		
Employer:			Employer:			
Work Phone #:			Work Phone #:			
Office Use Only	Form Received/ Completed By:			Entered By:		
	Form Scanned By:					

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Financial Agreement

In order to obtain reimbursement for services provided to my child by Northpoint Pediatrics, I authorize disclosure of my child's record for treatment, payment, and healthcare operations.

If my primary care physician is a participating provider in my insurance plan, I hereby assign medical benefits due be paid directly to Northpoint Pediatrics.

"I/we hereby designate Northpoint Pediatrics and its employees as my/our representative to file grievances and to represent me/us in accordance with the Indiana Code, Title 27, Chapters 8 and 13."

I understand that I am financially responsible for any balances not paid by my insurance carrier within 60 days from the date the services. If the patient fails to provide proof of insurance within 60 days, the patient is responsible for the balance in full. If no Secondary Insurance information is provided, I attest and affirm that I have no other insurance other than that listed as Primary Insurance. Patients with no insurance coverage are considered self pay patients and are eligible to receive a 10% discount only if paid in full at the time services are rendered.

I understand that if my child's account becomes delinquent it will be assigned to an attorney for collection and/or suit, and the prevailing party shall be entitled to reasonable attorney's fees and cost of collection and my family will be asked to seek medical care elsewhere.

This assignment will remain in effect until revoked by me in writing. A photocopy of the assignment is to be considered as valid as the original.

Please refer to the financial tab on our website, www.northpointpeds.com to review all of our financial and billing policies. Information on our billing, coding, benefit, insurance and payment policies can be located under this tab.

Note: Signature for acceptance of this policy will be made on the signature sheet.

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Consent for Communication via Electronic Mail.

I give my consent for Northpoint Pediatrics business office staff to communicate with me via email in regard to my child's account and insurance coverage.

By providing this email address the providers and staff at Northpoint Pediatrics will assume that they are communicating ONLY with the legal parent or legal guardian of the patient named above. Once the information to be communicated is sent to the above email address, the legal parent/legal guardian of the patient will be responsible for maintaining the security of the information. The legal parent/legal guardian must recognize that the information transmitted cannot be considered secure and that there is some risk to the patient that their personal protected health information may be accessed by others.

Email questions regarding billing and financial questions will be answered within 48 hours. All questions regarding the care and health of your child should be directed to your primary care doctor by calling 317-621.9000.

If you have any questions please email the Patient Account Team

at Mynorthpointaccount@ecommunity.com or call the

Patient Accounts office at 317-621-9183.

Communication via email is intended for insurance and billing matters only.

Northpoint Pediatrics does not provide any medical advice or treatment via e-mail

SIGNATURE FOR ACCEPTANCE AND AGREEMENT TO THIS POLICY WILL BE MADE ON THE SIGNATURE SHEET