REGISTRATION FORM

Thank you for choosing Dr. Merinda Herron as your child's healthcare provider.
Please fill out the front and back of this form completely.
Please print

DATE___/___/___ EMAIL ADDRESS_____

PATIENT _____ _____ _____ _____
LAST NAME FIRST NAME MI NICKNAME

BIRTHDATE___/___/___ SEX: [ ] MALE [ ] FEMALE ETHNICITY _____

RACE_____ LANGUAGE SPOKEN AT HOME_____

ADDRESS_____

CITY_____ STATE_____ ZIP CODE_____HOME PHONE NO_____

PARENT/GUARDIAN INFORMATION

PARENT/GUARDIAN NAME_____ _____ _____
LAST NAME FIRST NAME MI

ADDRESS IF DIFFERENT_____ CELL PHONE_____

BUSINESS ADDRESS_____ WORK NO_____

BIRTHDATE____/____/_____ ALTERNATIVE PHONE NO_____

PARENT/GUARDIAN INFORMATION

PARENT/GUARDIAN NAME_____ _____ _____
LAST NAME FIRST NAME MI

ADDRESS IF ADDRESS_____ CELL PHONE_____

BUSINESS ADDRESS_____WORK NO_____

BIRTHDATE____/____/_____ ALTERNATIVE PHONE NO_____

INSURANCE INFORMATION **COPY OF INSURANCE CARD REQUIRED**

INSURANCE COMPANY_____ POLICYHOLDER'S NAME_____

SUBSCRIBER/POLICY #_____ GROUP #_____ CO-PAYMENT $_____

INS. ADDRESS_____ STATE_____ ZIP CODE_____ PHONE_____

EMERGENCY CONTACT

NAME OF LOCAL FRIEND/RELATIVE (NOT LIVING AT SAME ADDRESS)

_____ _____ _____ _____
LAST NAME FIRST NAME PHONE NO RELATION TO PATIENT

Walk-In Policy

We no longer see patients on a walk in basis. Please call to schedule an appointment at least one hour before you wish to be soon. There is no guarantee there will be an appointment available at the time you need.

Patient Questionnaire

Completed by: _____ Relationship to patient:_____
Reason for todays visit:_____
Previous medical care provided by: _____

Family Medical History List all blood relatives of your child who have had the following medical problems. Circle the correct abbreviation F (father), M (mother), B (brother), S (sister), MM (mother's mother), MF (mother's father), FM (father's mother), FF (father's father), A (aunt), U (uncle), C (cousin).

Anemia	F	M	B	S	MM	MF	FM	FF	A	U	C
Asthma	F	M	B	S	MM	MF	FM	FF	A	U	C
Mental Retardation	F	M	B	S	MM	MF	FM	FF	A	U	C
Drug addiction	F	M	B	S	MM	MF	FM	FF	A	U	C
Alcoholism	F	M	B	S	MM	MF	FM	FF	A	U	C
Cancer	F	M	B	S	MM	MF	FM	FF	A	U	C
AIDS	F	M	B	S	MM	MF	FM	FF	A	U	C
Cystic Fibrosis	F	M	B	S	MM	MF	FM	FF	A	U	C
Muscle Dystrophy	F	M	B	S	MM	MF	FM	FF	A	U	C
Tuberculosis	F	M	B	S	MM	MF	FM	FF	A	U	C
Arthritis	F	M	B	S	MM	MF	FM	FF	A	U	C
Epilepsy/Seizure	F	M	B	S	MM	MF	FM	FF	A	U	C
Heart Disease	F	M	B	S	MM	MF	FM	FF	A	U	C
High Blood Pressure	F	M	B	S	MM	MF	FM	FF	A	U	C
Cholesterol	F	M	B	S	MM	MF	FM	FF	A	U	C
Migraine	F	M	B	S	MM	MF	FM	FF	A	U	C
SIDS	F	M	B	S	MM	MF	FM	FF	A	U	C
Birth Defects	F	M	B	S	MM	MF	FM	FF	A	U	C
Early Deafness	F	M	B	S	MM	MF	FM	FF	A	U	C
Diabetes	F	M	B	S	MM	MF	FM	FF	A	U	C

Family Profile
Parents _____ Married? _____ Separated? _____ Divorced
Father's Age _____ Highest level of education _____ Health? _____
Mother's Age _____ Highest level of education _____ Health? _____
List child's siblings and their ages:_____
_____
_____

Development compared to other children Grade in school _____
Behavior issues? _____ Yes _____No Learning difficulties? _____ Yes _____ No
If yes to any of above please explain: _____
_____
_____
_____

Merinda Herron, MD PC

Notice of Privacy Practices

Thank you for choosing us as your healthcare provider. We are committed to your child's overall health. The following is a statement of Our Office Policy, which we require you to read and sign prior to treatment. All patients must complete our patient information form and have their insurance verified before being treated.

_____ * **Payment methods**
Initial We accept cash, checks, money orders, debit and credit cards.

_____ * **Returned Checks**
Initial There is a returned check fee of $30.00 in addition to a cash equivalent to the amount of the returned check. We will not deposit checks a second time. We not accept a check s payment for the return of a check.

_____ * **Insurance**
Initial As a courtesy to you, we file your insurance claim at no extra charge. By signing our company policy you are authorizing your insurance company to send the payment to us. In the event that your insurance company will not send the payment to us, you will be asked to pay for services in full.
Changes in address, phone number, insurance or job are your responsibility. Please see our scheduling coordinator to update any of the above information.

_____ * **Collections**
Initials All fees associated with collection agencies, attorney, and court cost will be the responsibility of the patient or guarantor of the patient.

_____ * **Cancellations, Late Arrivals and No Shows**
Initials If for any reason you need to cancel an appointment please call at least 24 hours before the missed appointment. Please call the office if you are going to be more than 10 minutes late for you appointment. Failure to do so could result in your appointment being canceled. Patients who fail to keep appointments will not be given morning or late afternoon appointments. This is to ensure we are able to accommodate patients who come on time for their appointments.

Thank you in advance for you cooperation. Please let us know if you have any questions or concerns.

Sign: _____ Date: _____

By signing you are agreeing to accept and adhere to the above policy.

Merinda Herron MD PC

Multiple Insurance Notification Policy

Parents/Guardian/Adult Responsibility Party:

Please inform our office of **ALL** insurance Policies that cover your child. This includes **MEDICAID and its CMO'S** as well as any other insurance that provides coverage.

Private insurance is the primary carrier and therefore **you must pay applicable co-pay at the time if your visit**.

If your child has multiple insurance plans and you fail to inform us your additional coverage, any and all unpaid claims that are denied will immediately become your financial responsibility.

For accurate billing, all insurance information needs to be submitted at the time the claim is filed.

Thank you

X_____ Date:_____

Payment of Authorized Benefits

I request that payment of authorized benefits be made to Dr. Merinda Herron, MD.

I further authorize the release of any information necessary to process insurance claims or any medical information that is required for any health care related utilization review or quality assurance activities or any healthcare professional requiring this information.

I understand and acknowledge that this assignment of benefits does not relieve me of my financial obligation for all medical fees and charges incurred by me or my child/children. I hereby accept such responsibility, including but not limited to payment of those fees and charges not directly reimbursed to Dr. Merinda Herron by any insurance policy, self insurance program or other benefits plans.

This authorization will remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid as the original. I understand that I have the right to receive a copy of this authorization.

Parent/Guardian_____ Date: _____

Relationship to patient_____