Primary MD	☐ Rhodes	☐ Merrick
☐ Stanford	☐ Nolen	☐ Repp
☐ Weed	☐ Fox	☐ Pomtree

Patient Registration Information

Please *PRINT AND* complete **ALL** sections below!

Please Check One

☐ New Patient ☐ Update Patient

Patient's Personal Information

Sex: ☐ Male ☐ Female

Email:_____

Name:_____

last name first name initial

Date of Birth: ___/___/___ Social Security #: _____ - _____ - _____ Phone #: (_____)_____ Home ☐ Cell ☐

Other children in same household:

_____DOB_____SS#_____relationship to parent 1/parent2_____

_____DOB_____SS#_____relationship to parent 1/parent2_____

_____DOB_____SS#_____relationship to parent1/parent2_____

Race:

☐ White ☐ African American ☐ Asian

☐ Native Hawaiian/Other Pacific Islander ☐ Native American Indian/ Alaskan

☐ Other_____

Ethnicity (Origin):

☐ Not Hispanic or Latino

☐ Hispanic or Latino

Preferred Language:

☐ English ☐ Spanish

☐ Other_____

Parent/ Guardian 1

Relationship to Patient: ☐ Mother ☐ Father ☐ Guardian ☐ Other_____

Name:_____

last name first name initial

Date of Birth: ___/___/___ Social Security #: _____ - _____ - _____ Phone #: (_____)_____ Home ☐ Cell ☐

Address:_____Apt#:_____City:_____State:_____Zip:_____

Employer Name:_____ Work Phone: (_____)_____

Parent/ Guardian 2

Relationship to Patient: ☐ Mother ☐ Father ☐ Guardian ☐ Other_____

Name:_____

last name first name initial

Date of Birth: ___/___/___ Social Security #: _____ - _____ - _____ Phone #: (_____)_____ Home ☐ Cell ☐

Address:_____Apt#:_____City:_____State:_____Zip:_____

Employer Name:_____ Work Phone: (_____)_____

Patient's Insurance Information

If newborn, hospital of birth: ☐ Saline ☐ Baptist ☐ St. Vincent ☐ Other_____

Primary Insurance Name:_____ Employer Name / Phone #:_____

Address:_____City:_____State:_____Zip:_____

Policy Holder:_____Policy Holder Date of Birth:____/____/____Relationship: ☐ Parent ☐ Self ☐ Other

Policy #:_____ Group #:_____Copay: $_____

Secondary Insurance Name:_____ Employer Name / Phone #:_____

Address:_____City:_____State:_____Zip:_____

Policy Holder:_____Policy Holder Date of Birth:____/____/____Relationship: ☐ Parent ☐ Self ☐ Other

Policy #:_____ Group #:_____Copay: $_____

Pharmacy Information

Benton

☐ CVS ☐ Walgreens

☐ Economy Drug Store ☐ Wal-Mart

☐ Smith Caldwell

☐ Westside

Bryant

☐ Bryant Family Pharmacy

☐ CVS

☐ Wal-Mart

☐ Walgreens

Other

☐ Fred's-Haskell

☐ Fred's-Shannon Hills

☐ Other: _____

Emergency Contact Information

(Other than mom or dad)

Name:_____ Relationship to child: _____

Address:_____City:_____State:_____Zip:_____

Home Phone: ( )_____ Work Phone: ( )_____ Cell Phone: ( )_____

Central Arkansas Pediatric Clinic, PA
Financial Policy

In an effort to prevent any misunderstanding about our financial and billing policies, please take a moment to read the following information. We will gladly discuss any questions you may have about our policies.

If you do not have insurance, payment is due at the time services are rendered unless alternate payment arrangements are made with our billing staff prior to your visit. To assist you, we accept cash, checks, MasterCard, Visa, and Discover as forms of payment.

If you have insurance, we will file your primary and secondary insurance for you as a courtesy if you have provided us with your current and complete insurance information, and if you have authorized your insurance company to pay us directly. You must realize, however, that your insurance is a contract between you and your insurance company. Payment is your responsibility. If your insurance requires co-payments as a part of your plan, these payments are collected during our check-in process. Please keep in mind that if a service is not a covered benefit in your insurance plan, you are responsible for the payment to us.

We realize that temporary financial problems may affect timely payment of your account. If such problems arise, we encourage you to contact us promptly for assistance in the managements of your account.

In case of divorce, the parent signing this financial policy is responsible for any and all payments for services. Any legal agreement, or other disagreement, between two parties in a divorce must be dealt with between those parties and does not involve Central Arkansas Pediatric Clinic, PA.

If my child has dual insurance, I understand that it is my responsibility to coordinate benefits between the two insurance companies. Failing to do so will not stop the collecting process.

If you have any questions about the above information, please call our billing department at (501) 943-3015.
We are here to help you.

AUTHORIZATION: I have read and agree to the terms and conditions listed above. I hereby authorize the release of any medical information necessary to process my health insurance claim(s) and authorize payment of benefits directly to Central Arkansas Pediatric Clinic, PA. I understand I am financially responsible to Central Arkansas Pediatric Clinic, PA for charges not covered or denied by my insurance company. I further agree to pay the cost of collection, court cost, and other reasonable fees should they be required in the event of my non-payment. I further agree that a photocopy of this agreement shall be valid as the original.

Signature:_____ Date:_____

Revised 10/08/2018