



400 McCaslin, #103 * Louisville, CO 80027 * Phone (303) 666.7337 * Fax (303) 666.7379

PATIENT REGISTRATION

CVP ACCOUNT# _____

CHILDREN'S NAMES & BIRTHDATES

Name Last _____ First _____ Middle _____ __M__F Birth date _____

Name Last _____ First _____ Middle _____ __M__F Birth date _____

Name Last _____ First _____ Middle _____ __M__F Birth date _____

Name Last _____ First _____ Middle _____ __M__F Birth date _____

GUARDIAN/PERSON RESPONSIBLE FOR PAYMENT

Name Last _____ First _____ Middle _____ Relationship to patient _____

Home Address Street _____ City _____ State __ Zip _____

Which children live at this address? _____

Home Phone Number _____ Cell Phone Number _____

Email Address _____

Marital Status: __married__ __divorced__ __single__

Birth date _____ Social Security Number _____

Employer _____ Occupation _____

OTHER GUARDIAN'S INFORMATION

Name Last _____ First _____ Middle _____ Relationship to patient _____

Home Address Street _____ City _____ State __ Zip _____

****PLEASE COMPLETE THE BACK OF THIS FORM****

Which children live at this address? _____

Home Phone Number _____ Cell Phone Number _____

Marital Status: married divorced single

Birth date _____ Social Security Number _____

Employer _____ Occupation _____

Employer Phone Number _____

MEDICAL INSURANCE INFORMATION

Insurance Comapny name _____

Insurance Billing Address _____

ID# _____ Group # _____

Subscriber (parent) name _____ Effective date _____

“I authorize payment of medical benefits to Centennial Valley Pediatrics for professional services rendered & the release of any medical information necessary to process insurance claims. I authorize Centennial Valley Pediatrics to give my child/children reasonable & proper medial care by today’s standards.”

Signature of Patient/Legal Guardian _____ Date _____

INSURANCE COVERAGE WAIVER

I understand that my eligibility for coverage by _____ (name of insurance company) cannot be confirmed at this time. I wish to receive medical service from Centennial Valley Pediatrics. If it is determined that I am not eligible for coverage, I understand that I will be responsible for payment of all services provided.

Signature of Patient/Legal Guardian _____ Date _____

PRIVACY PRACTICES ACKNOWLEDGEMENT

“I have been provided the opportunity to review the Notice of Privacy Practices.”

Print your name _____

Signature of Patient/Legal Guardian _____ Date _____

Who may we thank for referring you to our office? _____

OFFICE POLICY

Payment in full is due at the time of service unless other arrangements have been made in writing through this office. We are not responsible for filing or collecting your insurance claims unless you are covered by one of our contracted insurances. It is agreed that payments will not be delayed or withheld because of any insurance coverage or pending claims. All proceeds of insurance are assigned to this office when applicable, but without this office assuming responsibility for the collection of the claim. Copayments are due at the time of service.

“I agree to pay, within a timely period, all deductibles and copayments assessed to my account. I agree that if it becomes necessary to forward my account to a collection agency, that, in addition to the amount owed, I may also be responsible for costs of collection, including attorney fees.

I certify that I have read, understand, and will comply with the above information.”

Guardian Signature _____ Date _____

ACKNOWLEDGEMENT OF EMERGENCY CARE PLAN

“I delegate Centennial Valley Pediatrics, or the medical provider(s) they may delegate, to provide any and all medical or surgical care which these children may require in the event that I am unavailable. This will apply only to situations where the delay of that care until such time as I might reasonably be expected to be available would be detrimental to the children. This includes my permission for the children to be admitted to a hospital and the performance of surgery and anesthesia as deemed advisable by the above-mentioned physicians or their delegates.

I hereby authorize Centennial Valley Pediatrics to administer such medications and perform such diagnostic work therapeutic procedures as may be necessary for the prudent medical care of my children.”

Guardian Signature _____ Date _____

EMERGENCY CONTACT (other than parent)

Name Last _____ First _____ Middle _____ Relationship to child _____

Home Address Street _____ City _____ State _____ Zip _____

Home Phone Number _____ Cell Phone/Work Number _____