CHARLES E. BALDWIN, M.D.

REGISTRATION FORM

(Please Print)

Today's date: PCP:

PATIENT INFORMATION

Patient's last name: First: Middle: Sex ☐ M ☐ F Birth date / / Age:

Parent's name: DOB: / / Email:

Street address: Social Security no.: Home phone no.: ( )

P.O. box: City: State: ZIP Code:

Occupation: Employer: Employer phone no.: ( )

Preferred pharmacy: Pharmacy phone number:

Other family members seen here:

INSURANCE INFORMATION

Person responsible for bill: Birth date: / / Address (if different): Home phone no.: ( )

Occupation: Employer: Employer address: Employer phone no.: ( )

Name of primary insurance:

Subscriber's name: Subscriber's S.S. no.: Birth date: / / Group no.: Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable): Subscriber's name: Group no.: Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address): Relationship to patient: Home phone no.: ( ) Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize CHARLES E. BALDWIN, M.D. or insurance company to release any information required to process my claims.

Patient/Guardian signature Date

Payment Policy

Here at the office of Dr. Charles E. Baldwin we are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance.** We participate in most insurance plans, including Medicaid. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
2. **Co-payments and deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.
3. **Non-covered services.** Please be aware that some -- and perhaps all -- of the services you receive may be non-covered or not considered reasonable or necessary by Medicaid or other insurers. You must pay for these services in full at the time of visit.
4. **Proof of insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
5. **Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.
6. **Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. I f your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.
7. **Nonpayment.** If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.
8. **Missed appointments.** Our policy is to charge for missed appointments not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.
9. **Surgery Appointments.** Canceling a surgical procedure 1 week (5 business days) prior to surgery, without a medical excuse, will be assessed a $75.00 cancellation fee. Rescheduling a surgery appointment to a different date is fine, as long as it is done in a timely manner.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of patient or responsible party Effective Date

Medical Questionnaire

Patient's Name: _____ DOB: _____

Reason for today's visit: _____

Name of Pediatrician or Doctor who referred you to us: _____

Any knows allergies: _____

List any current medication / reasons:

_____

_____

List any past hospitalizations and emergency visit:

_____

_____

List any past surgeries:

_____

_____

Any history of bleeding disorders in patient or family? _____

Any problems with anesthesia in patient or family: _____

List any known medical problems:

_____

_____

What grade is the child in? _____

Does he/she attend daycare? _____

Name of child's parent (s) or legal guardian (s): _____

Who lives in the household?

_____

_____

Any smokers in the home: _____

Any pets in the home: _____

Parent / Guardian signature: _____ Date: _____

CONSENT FOR TREATMENT

I, the undersigned, give my permission to Charles E. Baldwin, M.D. to give

_____ the following:
Print Patient's Name

☐ Routine Examinations/Treatments/Consultations

☐ Circumcision

I understand that this consent will remain in effect until I withdraw it in writing.

_____ _____
Date *Signature of Parent or Legal Guardian*

STATEMENT TO PERMIT PAYMENT OF COMMERCIAL BENEFITS

I certify that the information I have provided is complete and accurate. I have disclosed the names of all parties who may be liable in whole or part for payment of physician's services and understand I am responsible for any services not covered by my insurance plan.

I authorize Charles E. Baldwin, M.D. to release any information required in applying for payment on my behalf and I hereby assign payment to Charles E. Baldwin, M.D. for any services that Charles E. Baldwin, M.D. may render.

_____ _____
Date *Signature of Parent or Legal Guardian*

Acknowledgement of Review of
Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____

Signature of Patient, Parent or Guardian

_____

Date

_____

Name of Patient, Parent or Guardian

_____

Relationship to Patient