FAMILY PATIENT REGISTRATION

John Choi, MD, FAAP

Childrens' Names (please list all children patients)	Date of Birth	Sex	Ethnicity/Race

PRIMARY HOME ADDRESS (where children reside)
Street Address:
City, State, Zip:

PARENT/GUARDIAN #1	
Full Name:	Date of Birth:
Sex: ☐ Male ☐ Female	Relationship:
Street Address: (if different from child)	
City, State, Zip:	
Contact Phone:	
Email:	

PARENT/GUARDIAN #2	
Full Name:	Date of Birth:
Sex: ☐ Male ☐ Female	Relationship:
Street Address: (if different from child)	
City, State, Zip:	
Contact Phone:	
Email:	

COMMUNICATION - Please designate a primary email and phone number to receive reminders	
Primary Email:	Primary Telephone:

Medical Information: Our staff will make its best efforts to contact you by your preferred method of contact. In case we cannot reach you personally, we may we leave Protected Health Information (PHI) on your voice mail or email. This may include normal lab or test results, appointment reminders, and prescription or pharmacy information. Please select your option below indicating whether you agree or disagree:

☐ Yes, I agree to allow John Choi, MD, PC and staff to leave messages on my home or mobile phonevoicemail

☐ No, I prefer to not receive messages, but will contact the office when notified

ACCESS TO PATIENT PORTAL

Our office has a patient portal to allow patients to complete screenings and forms, and to access health information and administrative forms.

☐ Yes, I agree to allow John Choi, MD, PC and staff to enable access to the patient portal for my child.

☐ No, I do not authorize use of the patient portal, and will ask for paper copies of pertinent patient forms and surveys

BILLING AND INSURANCE INFORMATION

Name of Insurance Plan:_____

Subscriber Name_____D.O.B._/__/_____

ID Number:_____Group: _____

Verification of your insurance coverage is your responsibility. In the event that the medical services are not covered, the responsible party (parent/guardian) is financially responsible for the charges, even if your insurance plan subsequently notifies our office of the denial after the date of service.

You are responsible for knowing and understanding your policy, its benefits, and its exclusions and limitations. Please remember to notify our office of any changes in insurance coverage. If your plan requires, please designate our office as Primary Care Provider.

For our participating insurance plans, our office will file a claim to your insurance on your behalf and we will provide all necessary documentation of your visit to your plan, and by signing below, you authorize our office to apply for benefits and payment to be sent directly to our office.

All co-pays/outstanding balances are to be paid upon registration at each office visit. The caregiver (parent, relative, childcare provider) registering the patient is financially responsible for all co-pays/outstanding balances regardless of custody arrangements. Our office accepts cash, checks, and credit cards.

We recommend all patient or patient families, especially those whose insurance plan carries a deductible keep a credit card on file to ease billing and payment processing. Please refer to the separate Credit Card Authorization form.

PRIVACY POLICY

All Patient Health Information is private and confidential. John Choi, MD, PC may use and disclose the patient's personal health information in the course of providing health care to the patient, to coordiante care with other providers, to handle billing and payment, and to conduct quality assessments and certifications. Every patient or his/her parent/guardian will recieve a copy of the office Privacy Policy. Please sign below to acknowledge that you have received and read a copy of the Privacy Policy.

CUSTODY

Do both parents have joint custody of the children?

☐ Yes

☐ No

If there are any custody issues, please advise our office, and we will be happy to assist you. If necessary, please provide us with any court orders or agreements.

MEDICAL RECORDS

Please arrange for a copy of your child's past medical records to be sent to our office prior to your child's visIt Please ensure that all records, **most importantly, immunization records**, are included.

Medical records may be sent by mail or by fax: John Choi, MD, PC 5944 Hubbard Drive, Rockville, MD 20852
fax: 301-984-9491

CANCELLATION AND MISSED APPOINTMENT POLICY

You must provide at least 24-hour notice, if you need to cancel or reschedule your appointment. You should call our office at 301-984-9490 to notify us of the missed appointment.

If you do not provide our office with 24-hour notice, you will be charged a $50 missed appointment fee per child. Your credit card on file will be charged this fee on the date of the missed appointment.

If you arrive at your appointment, more than 15 minutes late, you may be required to reschedule the appointment.

AUTHORIZATION and CONSENT TO TREATMENT

I have read and understand the above policies and agree to the terms. I consent to the treatment of medical care for my child. Furthermore, I authorize the release of medical and necessary information of my child for medical care and health insurance claim purposes; and authorize payment of medical benefits to the physician for services.

_____

Parent/Guardian Signature **Date**