Dear Parent/Guardian

Welcome to our practice! We are so excited to meet you! Now that you have your first appointment with us scheduled, please complete this packet, and bring it in with you to your appointment.

If your insurance plan requires that a PCP *(Primary Care Provider)* be listed on your card, please be sure to call your plan, and change your PCP to Kristen Snow, NP. We also ask that you bring your insurance cards and a form of ID to <u>every</u> visit. Thank you for being a part of our practice! We will see you soon.

Sincerely,

Snow Family Medicine, LLC

Patient Registration Form

Patient Information

Last Name: _____ First Name: _____ MI: _____

DOB: _____ M/F Address:_____

City: _____ State: _____ Zip Code_____

Home Phone #: ( )_____Cell Phone#: ( )_____

Email: _____ SS#: _____

Preferred Pharmacy and Address:
_____
_____

Emergency Contacts

Name: _____ Relationship: _____
Phone #:

Name: _____ Relationship: _____
Phone #:

Name: _____ Relationship: _____
Phone #:

Guarantor Information (List person or insured name responsible for bill)

Relationship of Guarantor to Patient: Self __ Spouse __ Parent __ Other _____

Last Name: _____ First Name: _____ MI: _____

DOB: _____ M/F Address: _____

City: _____ State:_____ Zip Code: _____

Printed Name: _____

Signature: _____

Relationship to Patient: _____

Insurance Information

Please allow receptionist to photocopy your insurance ID cards

PRIMARY INSURANCE

Plan Name: _____ Policy #: _____

Insured's Name: _____ Insured's DOB: _____

Claim Address & Phone:

_____

_____

SECONDARY INSURANCE

Plan Name: _____ Policy #: _____

Insured's Name: _____ Insured's DOB: _____

Claim Address & Phone: _____

_____

If your insurance requires a Primary Care Physician, please make sure to have Kristen Snow FNP-BC listed on your card. If Kristen Snow is not listed as your PCP, your claim may be denied and you will be responsible for the full amount of the visit.

Printed Name: _____ Date: _____

Signature: _____

Relationship to Patient: _____

Authorization for Release of Medical Record Information

Patient Name: _____ DOB:_____ Phone No.:_____

Address: _____ City/State/Zip:_____

Records Requested From:

Facility Name: _____

Address: _____

City/State/Zip: _____

P: _____ F: _____

Requested to be sent to:

Snow Family Medicine, LLC

2220 Plainfield Pike, Cranston, RI, 02921

P: 401-585-8500

F: 401-942-2200

info@snowfamilymedicine.com

Please Review the following information (Check One)

__ All records, including those pertaining to substance abuse, HIV, AIDS, and mental health if applicable.

__ All records, not including those pertaining to substance abuse, HIV, AIDS, and mental health if applicable.

__ Immunization records only

Note: If the patient is a minor, the parent or guardian must sign. If the patient is an adult and does not sign this consent form, the party must provide legal documentation providing authority to do so.

This information will not be given, sold, transferred, or relayed to any other person not specified in this authorization without first obtaining my written consent which states the need for the proposed new use of this information, or the need for its being transferred to another person.

Understand that you, the patient will be liable for the reasonable transfer cost of $15.00 per patient if requesting your own private copy of your medical records.

Reason for Transfer: (Circle One)

Relocation Change of Provider Continuity of Care Change of Insurance Legal/Other

Relationship to Patient: _____ Date:_____

Printed Name:_____

Signature:_____

No-Shows, Missed Appointments and Late Check-in

OFFICE POLICY

(Effective September 15, 2016)

*** Please be advised that patients arriving more than 15 minutes late for their appointment will be considered a no-show and need to be rescheduled. ***

Missed Appointment Fees:

FOLLOW-UPS, SICK VISITS, SAME DAY VISITS	$30.00
PHYSICAL EXAMS AND WELL-CHILD VISITS	$50.00

When you do not show up for a scheduled appointment, it creates an unused appointment slot that could have been used for another patient. It is very important that you call *at least* **24 hours** in advance to your missed appointment.

If for any reason you need to cancel an appointment, please notify our office as soon as possible.

After **3 consecutive** no-show occurrences, the practice may elect to discontinue your care with this practice, and you may need to seek care elsewhere.

I understand that if I do not call and cancel my appointment *at least* **24 hours** in advance to my appointment, I will be charged the above fees.

Print name: _____

Signature: _____ Date: _____

If signed by someone other than the patient, provide relationship to patient: _____