SUNRISE PEDIATRICS
SANJAY KANDOTH, MD
3061 S MARYLAND PARKWAY SUITE #101 LAS VEGAS, NV 89109
PH # 702-254-KIDS (5437) FAX # 702-254-7354

NEW PATIENT REGISTRATION FORM
FORMA DE REGISTRACION PARA PACIENTES NUEVOS

PATIENT'S LAST NAME(APELLIDO)**:** **FIRST NAME** (NOMBRE): **MIDDLE NAME**(SEGUNDO NOMBRE):

DATE OF BIRTH (FECHA DE NACIMIENTO) : **PATIENTS AGE(**EDAD)**:** **PATIENT'S SEX M/ F(**GENERO M/F)**:**

RESPONSIBLE PARTY NAME: (PERSONA RESPONSABLE) **DATE OF BIRTH:** (FECHA DE NACIMIENTO) **SS #:** (# DE SEGURO SOCIAL)

HOME ADDRESS(DOMICILIO): **APT.#:** **CITY**(CIUDAD): **STATE**(ESTADO) **ZIP CODE**(CODIGO POSTAL)

HOME PHONE #(# DE CASA): **CELL PHONE #** (# DE CELULAR): **WORK PHONE #**(# DE TRABAJO):

EMAIL ADRESS (CORREO ELECTRONICO): **LANGUAGE PREFERRED(**IDIOMA): **ETHNICITY**(ETNICIDAD)**):**

SPOUSE NAME(NOMBRE DE ESPOSO-A)**):DATE OF BIRTH**(FECHA DE NACIMIENTO)**):** **SS** (# DE SEGURO SOCIAL):

PRIMARY INSURANCE INFORMATION (INFORMACION DE ASEGURANZA PRIMARIA)

NAME OF INSURED:____**RELATION TO PATIENT:**_____________________
(NOMBRE DE EL ASEGURADO) (RELACION CON EL PACIENTE)

DATE OF BIRTH:____**SOCIAL SECURITY #:**__________________________
(FECHA DE NACIMIENTO) (# DE SEGURO SOCIAL)

INSURANCE COMPANY:__________________________**POLICY ID #:**_____________________**LOCAL OR UNION #:**________
(NOMBRE DE ASEGURANZA) (# DE ID.) (# DE UNION O LOCAL)

EMPLOYER:__________________________________**DEPARTMENT:**_______________________**WORK PH #:**_______________

(NOMBRE DE EMPLEADOR) (DEPARTAMENTO) (# DE TEL. DEL TRABAJO)

SECONDARY INSURANCE INFORMATION (INFORMACION DE SEGUNDA ASEGURANZA)

NAME OF INSURED:____RELATION TO PATIENT:______________
(NOMBRE DE EL ASEGURADO) (RELACION CON EL PACIENTE)

DATE OF BIRTH:____S S #:______________________
(FECHA DE NACIMIENTO) (# DE SEGURO SOCIAL)

INSURANCE COMPANY:_______________________POLICY ID #:_______________________LOCAL OR UNION #:
(NOMBRE DE ASEGURANZA) (# DE ID.) (# DE UNION O LOCAL)

EMPLOYER: DEPARTMENT: WORK PHONE #:
(NOMBRE DE EMPLEADOR) (DEPARTAMENTO) (# DE TEL. DEL TRABAJO)

EMERGENCY CONTACT: PHONE #:
(CONTACTO DE EMERGENCIA) (# DE TEL.)

FINANCIAL POLICY ASSIHNMENT INFORMATION AND RELEASE OR INFORMATION

I AUTHORIZE RELEASE OF ANY INFORMATION ACQUIRED IN THE COURSE OF TREATMENT NECESSARY TO COMPLETE AND FILE MEDICAL CLAIMS TO MY INSURANCE COMPANY ON MY BEHALF. I HERBY ACKNOWLEDGE FINANCIAL RESPONSIBILITY FOR COST OF SERVICES RENDERED FOR THIS ACCOUNT WHICH I AM GUARRANTOR. I AUTHORIZE (ASSIGN) ALL INSURANCE OR MEDICAID BENEFITS TO BE PAID DIRECTLY TO DR KANDOTH / SUNRISE PEDIATRICS. I ASSUME RESPONSIBILITY FOR ELECTED NON-COVERED SERVICES AND SUPPLIES. ALL CO-PAYMENTS, CO-INSURANCE AND DEDUCTIBLES ARE DUR UPON ARRIVAL. I UNDERSTAND THAT ANY AND ALL FEES INCURRED FOR MEDICAL TREATMENTARE MY TOTAL AND ULTIMATE RESPONSIBILITY REGARDLESS OF ANY INSURANCE I MAY HAVE, IN THE EVENT THAT MY INSURANCE DOES NOT PROVIDE BENEFITS OR PROCIDE REDUCED BENEFITS AND I DO NOT PROVIDE MY INSURANCECCOMPANY NEEDED INFORMATION IN A TIMELY MANNER I WILL BEFINANCIALLY RESSPONSIBLE TO PAY UP THE AGREED UPON SCHEDULE. IF A COLLECTION AGENCY'S SERVICES ARE REQUIRED I FURTHER AGREE TO PAY COLLECTION AGENCY FEES AND OR ALL LEGAL FEES COURT COST AND REASONABLE ATTORNEY FEES.

RETURNED CHECKS:
THERE WILL BBE A $25.00 NSF FEE BY THIS OFFICE FOR AND INITIAL RETURN CHECK.

YO AUTORIZO CUALQUIER INFORMACION OBTENIDA EN EL CURSO DE TRATAMIENTO NECESARIO PARA COMPLETAR Y ARCHIVAR PAGOS MEDICOS A MI ASEGURANZA TENGO COMCIMIENTO DE RESPONSABILIDAD FINANCIERA POR LOS COSTOS DE LOS SERVICIOS RENDIDOS EN ESTA CUENTA DE LA CUAL SOY GARANTIA . AUTORIZO TODA ASEGURANZA O BENEFICIOS DE MEDICAID A SER PAGADOS A DR.KANDOTH / SUNRISE PEDIATRICS. ASUMO RESPONSABILIDAD DE TODOS LOS COSTOS NO CUBIETOS CO-PAGOS O DEDUCIBLES INDEPENDIENTE DE LA

ASEGURANZA QUE TENGA EN EL EVENTO QUE MI ASEGURANZA NO PROVEA BENEFICIOS O BENEFICIOS REDUCIDOS Y NO MUESTRO INFORMACION DE ASEGURAANZA A TIEMPO SERE RESPONSEBLE DE CUBRIR GASTOS EN TIEMPO ACORDADO SIES NECESARIO UNA AGENCIA DE COLECCION CARGOS LEGALES CORTE SERE RESPONSABLE DE CUBRIR GASTOS.

CHEQUES SIN FONDO:
ABRA UN CARGO DE $25.00 POR CHEQUES SIN FONDO

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____

SIGNATURE OF PATIENTS LEGAL GUARDIAN **DATE**
(FIRMA DEL GUARDIAN DEL PACIENTE) **FECHA**

____
____

PRINTED NAME OF PERSON SIGNING ABOVE **DATE**
(NOMERE ESCRITO DE LA PERSONA) **FECHA**

IN THE EVENT I AM NOT ABLE TO TAKE MY CHILD FOR MEDICAL SERVICES, I_________________________________
GIVE PERMISSION FOR THE FOLLOWING PERSONS TO TAKE MY CHILD TO SEE DR.KANDOTH.

EN EL EVENTO QUE YO ___________________________________ NO PUEDA ASISTIR A CONSULTA CON MI HIJO/A DOT PERMISO A LAS SIGUIENTES PERSONAS A TRAERLO/A CON EL DR.KANDOTH.

NAME (NOMBRE) BIRTHDATE (RECHA DE NACIMIENTO) RELATION (RELACION)

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SIGNATURE OF LEGAL GUARDIAN (FIRMA DE PADRE O GUARDIAN) DATE (FECHA)

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REQUEST FOR TREATMENT AND INSURANCE VERIFIVATION

This is to certify that I,___________________________________ authorize Sunrise Pediatrics to file claims to my insurance company or companies for services, rendered to me by Dr. Sanjay Kandoth or any of his medical providers, an affiliate of Sunrise Pediatrics. I certify that the information I have reported with regard to my insurance company is correct. I understand that I am responsible to notify Sunrise Pediatrics if my insurance company changes, benefits of my insurance plan and that failing to do so may result in lesser payment or no payment at all from my insurance carrier(s). I understand and agree that I am ultimately responsible for payment in full for all services that I have received from Sunrise Pediatrics.

If a referral is required, I understand that it is MY responsibility to obtain all documentation required by any insurance carrier or reimbursing agent in order to determine payable benefits.
____ Patient Initials

PAYMENT AT TIME SERVICES ARE RENDERED

I understand that payment of the Estimated Bill will be made at the time services are rendered. I understand that my Estimated Bill will be provided prior to leaving the office and will detail my expected out of pocket charges based on Sunrise Pediatrics' contractual fee with my insurer and the details of my particular insurance plan. The Estimated Bill will detail all deductible, co-pay and co-insurance expected to be owed by me to (insert physician name here). It is anticipated that my Explanation of Benefits will detail these charges after submission of my claim. My estimated payment could potentially result in an under-payment or overpayment base on my insurance carrier's determination of the filed claim. If an under-payment occurs, I understand that I will be billed for the remainder owed. Sunrise Pediatrics will issue a prompt refund for any overpayment that is made by me.
______ Patient Initials

PATIENT ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I have received the Notice of Privacy Practices (HIPAA) and I have been provided the opportunity to review the document.
________ Patient Initials

I have fully read and initialed the information in each section above, and with my signature below, agree to the terms and conditions listed in each section above.

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Signature of Patient/Responsible party   Date

Relationship to Patient (if applicable):
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