

FAMILY REGISTRATION FORM (Please print clearly)

Parent/Guardian Name (First and Last)		Parent/Guardian Name (First and Last)		
Address		Address (If different)		
City, State, Zip		City, State, Zip		
Home Phone		Home Phone		
Cell Phone		Cell Phone		
Preferred Phone Number to use for appointment info. and messages		Preferred Phone Number to use for appointment info. and messages		
Employer		Employer		
Date of Birth		Date of Birth		
<u>LIST CHILDREN BY BIRTHDATE, OLDEST FIRST</u>				
Name	Sex	Birthdate	Child's cell # (if applicable)	Legal Guardian (if applicable)
1)				
2)				
3)				
4)				
5)				
Insurance Company:		Insured's Name:		
Preferred pharmacy and phone number:				

INDIANA LAW REGARDING REFERRALS

A new Indiana law effective Jan., 2018 requires referring physicians to provide patients with a written notice of the following:

- (1) That an out-of-network provider may be called upon to render health care items or services to the covered individual during the course of treatment.
- (2) That an out-of-network provider is not bound by the payment provisions that apply to health care items or services rendered by a network provider under the covered individual's health plan.
- (3) That the covered individual may contact the covered individual's health plan before receiving health care items or services rendered by an out-of-network provider.
 - a. To obtain a list of network providers that may render the health care items or services; and for additional assistance.

I understand the above information regarding referrals.

Parents Signature _____ Date _____

PLEASE CONTINUE TO THE OTHER SIDE