## Child Registration – Newborn Nursery

**Pediatric service**

**Apple Pediatrics /Bodhi Medical Care, LLC**

157 East 72nd Street, New York, NY 10021
Phone: (888) 603-0993, Fax: (212) 624 0220
www.mybodhi.com

Dear Parent(s):

We would like to congratulate you on your new baby. Having a new baby is one of the most enjoyable moments in your life. As medical providers, we are happy to assist in the care of your child. The period at which your baby is in the Newborn Nursery can be overwhelming. We will be more than glad to assist you with your needs. Please note that the medical practitioners of Apple Pediatrics attending to your child and servicing the newborn nursery are private physicians whose service is independent of the hospital. As we provide the medical care to your child, this requires a similar registration with our practice as is done with the hospital. After the discharge from the hospital Apple Pediatrics / Bodhi Medical Care, LLC will submit invoices (claims) for the provided services. Please take a moment to fill out your demographic and insurance information.

| **Child's Last Name** | **Child's First Name ( If undecided Babyboy / Babygirl)** | **Child's DOB Month / day / year** |
|---|---|---|
| | | |
| **Child's home address: street/ apt** | **Child's home address : city and Zip code** | **Primary contacts phone / email** |
| | **City / state / zip code** | **Phone / email /** |
| **Responsible party– Last Name (under who will be the child insured)** | **Responsible party first name** | **Responsible party DOB Month / day / year** |
| | | |
| **Responsible party Insurance Name** | **Responsible party Insurance ID** | **If applicable : insurance group ID and Name** |
| | | |
| **Is the responsible party's address same as the child's? if yes please just write YES, below. If No, please add in:** | **Responsible party – street address (if different from child's home address)** | **Responsible party city / zip code (if different from child's home address)** |
| | | |
| **Responsible party contact phone** | **Responsible party contact –email** | |
| | | |
| **last name of the other parent** | **First name of other parent** | **Dob of other parent** |
| | | **Month / day / year** |
| **Other parent contact phone** | **Other parent contact email** | |
| | | |
| | | |

**Part II: General responsibility for payment:** Parents are generally responsible for all hospital and private pediatrician payments. Please note that that you have **30** days to inform your insurance carrier of your newborn. Missing this deadline can frequently cause denial of insurance coverage for the hospital and pediatric care. Also, frequently, if your insurance has a deductible or additional copayment, the insurance will require the parent(s) to be responsible for that portion of payment. Please note that your claims for our care will be submitted to the insurance based on the information you provided. Should you claim for the provided pediatric services be denied, or be designated by the insurer to be your responsibility, we then require the payment method for such services. Please note, that you will NOT be charged for the services unless your insurance(s) deny the payment, or you are delegated to be responsible.

Credit card type: Visa / Master Card/ American Express Name on the credit card:_____

Credit card #: _____ expiration date: _____/_____

**Should the insurance deny or delegate payment for my child's pediatric services due to invalid insurance ID, failure to activate child's insurance policy, delegated insurance copayment or deductible, I hereby authorize payment for the pediatric services provided to my child with a maximum of $200 per each day of service.**

_____ date_____

Signature:

# PART III. For providers only:

| **Diagnosis** | | |
|---|---|---|
| **Diagnosis 1** | **Diagnosis2 Diagnosis 3** | **diagnosis 4** |
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| | | |
| **date of admission** | | **Date of discharge** |
| | | |
| **Date(s ) seen by provider** | | |
| | | |
| | | |
| | | |
| | Date submitted for billing: | |
| | | |