



Wholistic Pediatrics

Primary Care, Allergies, Autism, ADHD, and Related Disorders

DAVID BERGER, M.D.

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REGISTRATION FORM

Patient Name: (Last, First): _____ **Patient Birth Date:** _____

Reason Being Seen: _____ **Sex (M/F):** _____ **Patient SS#** _____

Street Address: _____ **City, State:** _____

Zip: _____ **County:** _____ **Email Address:** _____

Insurance Company: _____ **Insurance ID #:** _____

f you have TRICARE please contact the office before submitting registration forms, as additional information may be required

Person Responsible for Patient/Account: _____

Address (If different from above): _____

Primary Phone (Circle One: Home/ Cell / Office): _____

Secondary Phone (Circle One: Home/ Cell / Office): _____

Emergency Contact: (Other than parent): _____

_____ Relationship to Patient: _____ ER Contact Tel #: _____

Consent to Provide Treatment

I hereby consent to allow David S. Berger, MD, PA (DBA Wholistic Pediatrics) to provide medical and other care, including but not limited to examination, diagnostic procedures, and treatments. I acknowledge that I may rescind this consent at any time. Signatures of all legal guardians are required for a minor to be treated. If unable to provide other guardian's signature, please explain why.

Patient/Parent/Guardian (circle one): _____ Date: _____

Patient/Parent/Guardian (circle one) _____ Date: _____

Financial Responsibilities

I agree to pay for all services and products provided by David S Berger, MD, PA (DBA Wholistic Pediatrics). I acknowledge that this medical practice operates on a "fee-for-service" basis and does not contract with any medical insurance company. All services/products must be paid for at time the service or product is provided. Upon request, Wholistic Pediatrics will provide insurance forms that can be submitted by the responsible party. This does not guarantee there will be any reimbursement. I understand that consultations may be provided either in person or by telephone, and will pay the fees for any type of consultation, regardless of whether my insurance company will or will not reimburse me for the fees. (The office does not routinely charge for phone time with the doctor that is less then 5 minute to discuss particular urgent or acute care or after hours problems).

If for some reason there is an outstanding balance on my account, I agree to permit David S. Berger, MD, PA (DBA Wholistic Pediatrics) to charge my credit card to clear any outstanding balance.

I have been given an opportunity to view a copy of the HIPAA privacy laws under which David S Berger, MD, PA (DBA Wholistic Pediatrics) practices. I also have reviewed and am aware of the office policies.

I acknowledge that I understand there is a firm 24-hour cancellation policy, and I will be responsible for the Doctor's fees for any cancellations or no-shows that happen within 24 hours business hours (i.e. 10AM Friday for a 10AM Monday appointment) if the appointment slot cannot be filled. If part of the appointment time can be filled, I will only be billed for the remaining time.

Responsible Party Signature: _____ **Date:** _____