# CENTER FOR PEDIATRIC WELLNESS, P.C.

**Your provider and your insurance carriers require this data before your child can be seen.**

**All information must be fully complete to assure the best treatment for your child/children.**
**PLEASE PRESENT YOUR CHILD/CHILDREN'S INSURANCE CARDS AT EACH VISIT.**

**Patient: Full Legal Name** ☐ **M** **Nickname:**_____

_____ **F** **DOB:**_____ **Preferred Language:**_____

**Address:**_____ **City:**_____ **State:**_____ **Zip:**_____

**Home Phone:**_____ **Patient Lives With?** ☐ **Mother** ☐ **Father** ☐**Both**

**Pharmacy:**_____**Address:**_____ **Phone:**_____

**Race:** ☐ **American Indian or Alaska Native** ☐ **Asian** ☐ **Black or African American** ☐ **White**
☐ **Native Hawaiian or other Pacific Islander** ☐ **Other** ☐ **Unknown** ☐ **Declined Information**

**Ethnicity:** ☐ **Not Hispanic or Latino** ☐ **Hispanic or Latino** ☐ **Patient declined information**

**SIBLINGS:**

| Full Name | DOB | M/F | Full Name | DOB | M/F |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

**Mother:**
**Full Name:**_____
**Address:**_____
**City:**_____ **State:**_____ **Zip:**_____
**Cell #:**_____ **Maiden Name:**_____
**DOB:**_____ **Email:**_____
**Employer**_____ **Work #:**_____

**Father:**
**Full Name:**_____
**Address:**_____
**City:**_____**State:**_____ **Zip:**_____
**DOB:**_____ **Email:**_____
**Employer:**_____
**Cell #:**_____

***PERSON RESPONSIBLE FOR BALANCES AFTER INSURANCE PAYMENTS*:**_____

**Insurance Information: (Must be completed in order to file your insurance) or provide a clear copy of the front and back of each child's insurance card.**

**Primary Subscriber's Name:**_____ **DOB:**_____ **Relationship to Patient:**_____

**Insurance Name:**_____ **ID#:**_____ **Group #:**_____

**Claims Address:**_____

**The following people are authorized to bring my child for any necessary treatment and may sign informed consent forms in my absence.**

_____ / _____ / _____

_____ / _____ / _____

**I certify that the information listed above is complete, accurate, and up to date.**

**Signature:**_____ **Date:**_____

# CENTER FOR PEDIATRIC WELLNESS, P.C.

## FINANCIAL POLICY

*Thank you for choosing Center for Pediatric Wellness, P.C. as your health care provider. The following is a statement of our Financial Policy which we require you to read and sign prior to treatment.*

Due to frequent changes in health insurance coverage, we require that you provide proof of insurance coverage at each visit. If you do not have insurance, are unable to provide proof of insurance, or are on a plan in which we do not participate, full payment is required at the time of your visit.

All co-payment, coinsurance and deductibles are due at the time of service. These fees can not be waived. All copayments not collected at the time of service will incur a $10 billing fee. Please also be aware that some services provided may be non-covered services and not reimbursable by your insurance. You are personally responsible for these services. For your convenience we accept cash, checks, Visa/MasterCard and Discover.

If we are a participating provider, we will file your insurance for each visit. Should there be a dispute with your insurance company, our billing department will attempt to resolve it for you. During this time the balance may be transferred to your responsibility. Please note that your insurance policy is a contract between you and your insurance company, therefore your balance is your responsibility.

Financial arrangements for balances due can be made through a payment program. Failure to resolve any past due accounts, including returned checks will result n your account being transferred to a collection agency and possible dismissal from the practice. You will be responsible for any fees associated with the cost of collections in the amount up to 40% of your balance in addition to the amount owed on your account.

Missed appointments for routine/preventive care are very disruptive to this office and deprive others from an appointment to see a doctor. We ask that you provide a Twenty-four (24) hour notice to cancel an appointment in order to avoid an $80 charge.

Request for transfer of medical records will incur an administrative fee of $15 per child up to two and $35 for a family of three or more payable prior to record preparation. Seven to ten working days are required to complete requests for medical records. An immunization record can be provided at no charge for active patients.

There is a $5 administrative fee to complete forms, (camp, school, sports, etc) not associated with routine visits. There is no charge for the required state forms unless they must be replaced. We ask for 72 hours to complete all forms. Rush forms including ADHD medication refills incur a $20 rush Fee.

ASSIGNMENT OF BENEFITS/MEDICAL RELEASE AUTHORIZATION

I authorize the release of any medical or other information necessary to process my child/children's insurance claims. This includes the release of medical information to other doctors or insurance companies for referrals or continuing medical care. I authorize payment of medical benefits to Center for Pediatrics Wellness, P.C. for services rendered and agree to the financial policies of Center for Pediatric Wellness P.C.

I acknowledge that I have read and understand the policies stated above. I agree to pay any monies due at the time of service and provide accurate insurance information at assist Center for Pediatric Wellness, P.C. in timely filing and prompt payments of my claims.

_____

Parent/Guardian Signature & Date

In the event that I am unable to be reached, I give permission to Center for Pediatric Wellness, P.C. to treat my children

_____

Parent/Guardian Signature & Date