

PEDIATRIC PARTNERS, LLC PATIENT REGISTRATION

PATIENT INFORMATION

PATIENT LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH	M / F SEX
			() -	
STREET ADDRESS	CITY/STATE	ZIP CODE	HOME PHONE NUMBER	
				M / F
SIBLING LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH	
				M / F
SIBLING LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH	

PARENT/GUARDIAN INFORMATION

MOTHER'S NAME	DATE OF BIRTH	SOCIAL SECURITY #
		() -
MOTHER'S ADDRESS IF DIFFERENT FROM PATIENT'S		CELL PHONE
		() -
MOTHER'S EMPLOYER	WORK PHONE	
FATHER'S NAME	DATE OF BIRTH	SOCIAL SECURITY #
		() -
FATHER'S ADDRESS AND PHONE # IF DIFFERENT FROM PATIENT'S		HOME PHONE
		() -
FATHER'S EMPLOYER	CELL/WORK PHONE	

INSURANCE INFORMATION (IF SIBLINGS HAVE DIFFERENT INSURANCE PLEASE NOTE)

PRIMARY INSURANCE COMPANY NAME: _____		
COPAY \$ _____	CLAIMS ADDRESS _____	
EFFECTIVE DATE _____	MEMBERSHIP # _____	GROUP # _____
POLICY HOLDER NAME _____		
SECONDARY INSURANCE COMPANY NAME: _____		
COPAY \$ _____	CLAIMS ADDRESS _____	
EFFECTIVE DATE _____	MEMBERSHIP # _____	GROUP # _____
POLICY HOLDER NAME _____		

We will gladly submit your bill to your insurance company. However, some procedures may not be covered or payment may be denied for other reasons. In that case, your signature below indicates that you will be responsible for any amount not covered or denied by your insurance company.

PATIENT BENEFITS/RECORD RELEASE

I authorize Pediatric Partners to release medical information as it is necessary to bill my insurance carrier. In addition, I authorize my insurance carrier to release payments of insurance benefits to Pediatric Partners.

SIGNATURE _____

DATE _____

FINANCIAL POLICY

Pediatric Partners LLC, is dedicated to providing our patients with the best possible care and services while keeping the costs to you from increasing at an unreasonable rate. We ask your help by understanding and cooperating with our financial policy.

Insurances: We participate with several insurance companies. Please check with the office to see if we participate with your plan.

All patients will be responsible for presenting their insurance card at every visit and for completing a new patient registration yearly.

If we DO participate with your insurance company, all services performed in our office and at the hospital will be submitted to them, unless we have received prior notification of non-covered services. All copays and deductibles are the patients' responsibility. All patients are responsible for ALL copayments at the time of service. Deductibles will be billed to you by our billing office.

If we DO NOT participate with your insurance company, this means that we do not bill your insurance carrier: and, we will not accept payment from them as payment in full for the services performed. We do not participate with PIP plans. Any balance not covered by the insurance company becomes the responsibility of the patient. Payment for services rendered in the office **IS** due at the time of service. We will provide you with an itemized bill so that you may submit the charges to your insurance company for reimbursement.

We DO NOT bill for secondary insurance unless the patients secondary coverage is Blue Shield, Tricare, Medicaid or a Medicaid Managed Care Organization. It becomes the responsibility of the patient to submit to all other secondary insurances. Patients are responsible for all balances following primary insurance payment unless otherwise noted above.

If you do not have insurance or an insurance card is not presented, all services performed will become the responsibility of the patient. Payment for services rendered in the office **IS** due at the time of service.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent bringing the child in for treatment will be the parent responsible for those subsequent charges.

Records, Forms and After-Hour Calls: You will need to request in writing, and pay a \$20.00 fee per medical record if you would like a copy of your record sent to another doctor or organization (no family discounts). You will also be asked to pay a reasonable fee of \$5.00 for completion of each summary and immunization form. In addition, you will be charged a fee of \$15.00 for all after-hour calls.

Interest Charge: Effective January 1, 2008, we will begin assessing an 18% APR interest rate on patient statements. Interest will be charged on patient balances greater than 60 days.

Missed Appointment Charge: Effective November 1, 2008, we will begin charging \$25.00 for all missed appointments.

It is important for you to understand that your health insurance coverage is an agreement between you and your insurance company and your doctor's bill for the services provided to you is an agreement between you and your doctor.

Payment for services performed:

Our office accepts VISA and Mastercard for your convenience, as well as cash or a check. Each bounced check will be assessed a fee of \$28.00. This fee is the responsibility of the patient and not the insurance company. All copayments not paid at the time of service will be assessed a service charge of \$10.00 per copay. All payments are expected at the time of service and any outstanding balances are due within 30 days of billing, unless prior arrangements have been made with the Billing Department. All balances that reach 90 days may be sent to a collection agency. Balances sent to the collection agency will be reported to a credit reporting agency. Should your account be sent to a collection agency, you will be financially responsible for all collection fees that our office incurs through the process utilized to collect the outstanding delinquent balance.

Payment in full of any past due balance is expected prior to being seen in our office in the future, unless prior arrangements have been made with the billing office.

I HAVE READ AND FULLY UNDERSTAND THE FINANCIAL POLICY SET FORTH BY PEDIATRIC PARTNERS LLC, AND I AGREE TO THE TERMS OF THIS FINANCIAL POLICY. I ALSO UNDERSTAND AND AGREE THAT THE TERMS OF THE FINANCIAL POLICY MAY BE AMENDED BY THE PRACTICE AT ANY TIME WITHOUT PRIOR NOTIFICATION TO THE PATIENT.

Signature of Patient and/or Guardian (SEAL)

Date

Patient Name(s) _____