NORTH WILLOW GROVE PEDIATRICS, P.C.

Date:__________

FAMILY NAME:

Father:_________________________ S.S.#:___________________D.O.B.________

Mother:________________________ S.S.#:___________________D.O.B.________

Children:____

Street Address:__________________________ Town:_______________________

State:____Zip:________Phone:_________________Best Time to Call:__________

Email (optional) _________________________________

Mother's Employer:_______________ Work#__________ Cell#_______________

Father's Employer:________________ Work#__________ Cell#_______________

As the parent/legal guardian of the child(ren) named above, I give permission for the following person(s) to authorize any and all medical treatment and to be contacted in case of an emergency.

Emergency Contact:__________________ Phone:__________Relationship:________

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Pharmacy:______________________________ Phone:______________________

Street and Town: ___________________________________

PRIMARY INSURANCE CO.:

Insurance:_________________ Name of Insured:__________________________

ID#:______________________ Group#:________________________________

SECONDARY INSURANCE CO.:

Insurance:_________________ Name of Insured:__________________________

ID#:______________________ Group#:________________________________

I authorize the release of any medical information necessary to process the claim.

We are committed to providing you with the best possible care. If you have medical insurance, we wish to help you receive your maximum allowable benefits. To achieve this, we need your understanding and assistance with our financial and payment policy.

Payment is required at the time of service. We accept cash, check or credit card (Visa or Mastercard).

For patients with *private* or *no insurance*, full payment is required at time of service.

For patients with **HMO plans,** co-payment is required at the time of service. The amount of co-payment varies with different plans.

While the filing of insurance claims is a courtesy that we extend to our patients, *all charges not covered by your insurance company are your responsibility.*

Evening and weekend appointments are billed to your insurance company with a surcharge. YOUR insurance plan may make YOU responsible for this service. The maximum that this fee would be to you is $25.00. Your insurance company can advise you if this is covered.

Well exams for children over 3 years old will include a **vision screening and hearing test.** They may not be covered by your insurance plan. The maximum that you would be responsible for these services is

Vision screening	$ 30.00
Hearing test	$ 25.00

Please contact your insurance company if you have questions about coverage of these services.

Bills unpaid for more than 90 days will be turned over to a collection agency unless other arrangements have been made. Accounts that are turned over to collections may result in dismissal from the practice.

If special circumstances make immediate payment impossible, payment arrangements must be approved in advance by our business office staff.

Missed appointments: Unless cancelled at least 24 hours in advance, there will be a $20 charge for missed appointments. Please help us serve you better by keeping scheduled appointments. Multiple missed appointments may result in dismissal from the practice.

I have read the above Financial Policy. I have understood it and agree to it.

Signed:________________________________ Date:________________________