Eastern Shore Children's Clinic

Updated Patient Information

Child's Last Name _____Child's First Name_____Child's Middle Initial ___

Preferred Name _____Birth Date _____SSN#_____

Primary Language (circle): English I Spanish I French I Other:_____

Ethnicity (circle): Hispanic I Non-Hispanic I Unknown

Race (circle): American Indian/Alaskan I Asian I Black I White I Other:_____

Address_____

City/State/Zip_____

Primary Phone _____ Daytime Phone _____ Cell Phone_____

Parent's marital Status (circle) Married | Divorced | Single | Widowed

Child lives with (circle one) Both parents | Mother | Father | Other _____

Parent / Guardian Name _____ Cell # _____

Email:_____ Will you accept email/text notifications: Yes I No

Parent / Guardian Name _____ Cell # _____

Email:_____ Will you accept email/text notifications: Yes I No

Primary Care Provider

Circle the name of the provider that you identify as your child's Primary Care Provider.

Dr. Burns | Dr. Drummond | Dr. Breslin | Dr. Moore | Dr. Orr | Dr. Walker | Akins (CRNP)

Pharmacy Information

Preferred Pharmacy | City | State | Phone Number_____

Insurance Information

Please provide Insurance card(s) and Driver's License so we can copy for our records

Subscriber's Last Name_____First Name_____Middle Initial___

Gender (circle) Male | Female Date of Birth _____Relationship to Subscriber_____

Insurance Company_____ Policy Number_____Group#_____

Co-pay Amount_____ Secondary Insurance? Y or N

Family Information

Sisters (Full Name)	DOB	Brothers (Full Name)	DOB

Signed _____Date_____Relationship to Child_____

EASTERN SHORE CHILDREN'S CLINIC
FINANCIAL POLICY

We here at Eastern Shore Children's Clinic (ESCC) are doing everything possible to hold down the cost of medical care. You can help a great deal by eliminating the need for us to bill you. The following is a summary of our financial policy.

ALL PAYMENT IS EXPECTED AT THE TIME OF SERVICE

Payment is expected at the time services are rendered unless other arrangements have been made in advance. I understand that I am responsible for any unpaid balance, copayments, coinsurance, deductibles and non-covered charges and unconditionally guarantee payment in full to ESCC for all treatment and services rendered to the patient. Failure to pay copayments on the service date may result in an additional fee. ESCC accepts cash, checks, debit cards, VISA, MasterCard, American Express, and Discover. There is a service charge for returned checks and we reserve the right to make your account a "cash only" account for future visits.

Patients with an outstanding balance are asked to pay their balance in full at time of receipt of their statement. We do realize that patients may have financial difficulty. Therefore, we advise you to call our Patient Account Representative, at 928-0624, extension 233, Tuesday through Friday between 9:00 a.m. and 4:00 p.m. to discuss your account.

INSURANCE

We bill participating insurance companies as a **courtesy** to you (*this includes Commercial Insurance, Group Insurance, and Medicaid*). You are expected to be familiar with what your copayment amounts are, what your yearly deductible is, what your insurance does or does not cover, etc. There are too many plans within plans for us to be able to know them all. Your employer provides numbers for you to call to ask these questions. When we check for eligibility at the time of your appointment and your insurance shows ineligible, you are responsible for the entire bill at the time of service.

MISSED APPOINTMENTS / LATE CANCELLATIONS

Cancellations should be made no later than 1 hour prior to your scheduled appointment time. Appointments not cancelled at least 1 hour prior will be considered "no-shows". Arriving more than 15 minutes late for an appointment will also be considered a no-show. No-show appointments represent a cost to us, to you, and to other patients that could have been seen at the time set aside for you. We reserve the right to bill you $25 for each no-show. After three (3) no-shows we reserve the right to dismiss your family from our practice.

I have read and understand the ESCC Financial Policy. I agree to assign insurance benefits to ESCC whenever necessary. I also agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I also will be responsible for the 33% fee charged by the collection agency on the total balance owed.

Signature of Insured or Authorized Representative: _____

Printed Name of Insured or Authorized Representative: _____

Date:_____