PATIENT INFORMATION

Name _____ Date of Birth_____

Address _____ Home Phone _____

City _____ Cell Phone _____

State _____ Zip Code _____ Work Phone _____

E-Mail Address _____

Primary Care Physician _____

SIBLING INFORMATION

Name _____ Date of Birth_____

Name _____ Date of Birth_____

Name _____ Date of Birth_____

AUTHORIZATION FOR TREATMENT AND RELEASE OF INFORMATION

_____ Initial I, _____, authorize Parkway Pediatrics to contact me by telephone with medical information pertaining to my (child's) care. If I am unavailable, this authorization gives Parkway Pediatrics permission to leave this information on my cell phone or with a member of my family whom I have authorized above.

_____ Initial I authorize Parkway Pediatrics or whomever they designate to evaluate and treat me/my child and to release to my insurance company any information acquired in the course of my/my child's examination, and to receive all payments for such examination or treatment. Parkway Pediatrics has my permission to release any diagnostic studies, reports, etc., to a specialist involved in my/my child's care.

PAYMENT POLICIES

_____ Initial **Insurance Information:** Insurance card(s) must be presented at the time of service. A copy of your insurance card(s) will be made for your file. It is your responsibility to provide updated insurance information at the time of service. If the insurance card(s) is not presented at the time of service, the charges are your responsibility until a copy of the insurance card(s) is received. For services to be billed to your insurance company, a copy of the insurance card(s) must be received within 10 days from the date of service.

_____ Initial **Account Balances:** When insurance information is received *after* the timely filing requirements of your insurance company, the charges for those services are your responsibility. **You are responsible for payment of all services not paid by your Insurance company, including all screenings and testing done at the time of well visits.** We accept cash, checks or credit cards. Parkway Pediatrics reserves the right to reschedule or deny future appointments for delinquent accounts.

_____ Initial **Co-Payments a**re expected to be paid at the time service is rendered. If payment is not received at the time of service, there will be an additional fee. All returned checks will be subject to a service charge of $30.00.

_____ Initial **Self-Pay:** Payment is expected at the time of service unless other financial arrangements have been made prior to your visit.

_____ Initial **Referrals:** If your plan requires referrals for specialty care recommended by your primary care physician, it is your responsibility to obtain information regarding these requirements and let our office know to request a referral to be processed prior to the specialty appointment.

_____ Initial **Evening, Weekend & Holiday Code:** Please be aware, we report all evening, weekend and holiday visits to your insurance carrier. This code may or may not be covered by your insurance.

_____ Initial **No Shows:** A $50 no show fee may be assessed for all office visits not previously cancelled.