**READING PEDIATRICS**

***Financial Responsibility Form***

**Patient's Name:** _____ **DOB:** _____

**Address:** _____

Street City State/Zip

**Mother's Information:**

Name: _____

Date of Birth: _____

Phone: _____

E-Mail: _____

Previous Patient of Reading Pediatrics: ☐ Yes ☐ No

**Father's Information:**

Name: _____

Date of Birth: _____

Phone: _____

Email: _____

Previous Patient of Reading Pediatrics: ☐ Yes ☐ No

**Preferred Language:** ☐ English ☐ Spanish ☐ Other: _____

**Patient Ethnicity:** ☐ Hispanic or Latino ☐ NOT Hispanic or Latino

**Patient Race (Check all that apply):** ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ White ☐ Native Hawaiian or Pacific Islander

**Mother's Insurance Name:** _____ Adding Baby: YES ☐ NO ☐

ID #: _____ Effective Date: _____

Subscriber* Name : _____ Subscriber DOB : _____

Subscriber Relationship to Patient: _____ Copy Card: _____

**Father's Insurance Name:** _____ Adding Baby: YES ☐ NO ☐

ID #: _____ Effective Date: _____

Subscriber* Name : _____ Subscriber DOB : _____

Subscriber Relationship to Patient: _____ Copy Card: _____

** Subscriber is the primary insurance holder – this could be yourself, your spouse/partner, or your parent*

**If not adding baby to either insurance above: ☐ CHIP ☐ Medical Assistance ☐ Other:** _____

**Guarantor (Person Responsible for Payments):** ☐ Mother ☐ Father ☐ Other: _____

**Address of Guarantor if different from above:**

_____

Street City State/Zip

I hereby authorize READING PEDIATRICS, INC to apply for benefits on my behalf for covered services rendered by him/her, or by his/her order. I request that payment from my insurance company be made directly to READING PEDIATRICS, INC. I understand that I am financially responsible for any balance not paid by my insurance. Balances are to be sent to the guarantor listed above. Payment is expected within 30 days of receipt.

Date: _____ Signature: _____ Print: _____

Date: _____ Received By: _____