INSURANCE INFORMATION

PRIMARY INSURANCE:

NAME OF INSURANCE: ______________________________

NAME OF INSURED: ______________________ DATE OF BIRTH: ____________

POLICY NUMBER: ______________________ GROUP #: ______________

INSURANCE PHONE NUMBER #: ______________________________

INSURANCE ADDRESS: ______________________________

SECONDARY INSURANCE:

NAME OF INSURANCE: ______________________________

NAME OF INSURED: ______________________ DATE OF BIRTH: ____________

POLICY NUMBER: ______________________ GROUP #: ______________

INSURANCE PHONE NUMBER #: ______________________________

INSURANCE ADDRESS: ______________________________

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ETHNICITY: (PLEASE CIRCLE ONE):

HISPANIC OR LATINO   NOT HISPANIC OR LATINO   DECLINE TO ANSWER

RACE: (PLEASE SELECT ALL APPLICABLE):

AMERICAN INDIAN / ALASKA   ASIAN   BLACK / AFRICAN AMERICAN

NATIVE HAWAIIAN / OTHER PACIFIC ISLANDER   WHITE / CAUCASIAN

DECLINE TO ANSWER

YOU ARE FINANCIALLY RESPONSIBLE FOR ALL CHARGES INCURRED, REGARDLESS OF INSURANCE COVERAGE. PLEASE READ THE FOLLOWING CAREFULLY. BY SIGNING BELOW YOU INDICATE YOU UNDERSTANDING AND ACCEPT THE FOLLOWING POLICIES:

1. I authorize the release of any medical or other information necessary to process my insurance claims. I authorize the release of medical records for the purpose of medical referrals and to the persons listed above.
2. I authorize the release of medical information to schools, camps, or other programs after my written or verbal request.
3. I have received and read the HIPPA policy for **Advanced Pediatrics**.
4. I authorize payment of medical benefits from my insurance company and government program to **Advanced Pediatrics.**
5. I agree to pay all insurance copays and or coinsurance at the time of visit. Or if I **DO NOT** bring current proof of insurance to each visit, I agree to pay charges in full before the patient is seen.
6. If **Advanced Pediatrics** cannot verify my insurance at the time of the visit, or if I did not bring current proof of insurance to each visit, I agree to pay any charges in full before the patient is seen.
7. If any charges incurred by me or my dependents are submitted to the collection agency, I agree to pay all fees including but not limited to, both the collection agency fees and the account balance.
8. If I miss any appointments without 24 hour notice, I agree to pay $25.00 **NO SHOW** charge.
9. I agree to pay a return check fee of $25.00 plus the amount of check if my personal check is returned by my bank.
10. While your appointment may be for a specific time, no express or implied guarantee is made that a nurse or physician will see you at that exact time. **Advanced Pediatrics** makes every effort to see patients in a timely fashion, subject to patient volume and emergencies beyond our control. I agree to not hold **Advanced Pediatrics** responsible in any manner for time spent waiting to be seen.
11. I understand that **Advanced Pediatrics** bills insurance as a courtesy. I understand that my financial charges for services rendered by **Advanced Pediatrics** are ultimately my responsibility.

RESPONSIBLE PARTY : ____
Print

RESPONSIBLE PARTY :________________________________DATE: __________
Signature