CARMEL PEDIATRICS, P.A.
PATIENT AND INSURANCE INFORMATION

PATIENT INFORMATION

Patient's Name ______________________________ **MD. RCD.#:** ______________
(office use)

Sex: M F Birth Date ______________________ **Soc. Sec. #** ______________________

Address ____

City ____________________ State ____________________ Zip____________

PARENT / GAURDIAN INFORMATION

Mother ____

Address ____

Home Phone # ____________________ **Cell #** ____________________

Work Phone # ____________________ **Email** ____________________

City ____________________ **State** ____________________ **Zip** ____________

Birth Date ____________________ **Soc. Sec. #** ____________________

Employer ____

Address ____

City ____________________ **State** ____________________ **Zip** ____________

Father ____

Address ____

Home Phone # ____________________ **Cell #** ____________________

Work Phone # ____________________ **Email** ____________________

City ____________________ **State** ____________________ **Zip** ____________

Birth Date ____________________ **Soc. Sec. #** ____________________

Employer ____

Address ____

City ____________________ **State** ____________ **Zip**
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PATIENT INSURANCE INFORMATION

Insurance Company Name ____

Policy # ____________________ **Group #** ____________________

Authorization and Assignment: I hereby authorize and assign payment directly to Carmel Pediatrics, PA of any surgical and/or medical benefits otherwise payable directly to me for services rendered to the above identified patient. I further authorize Carmel Pediatrics, PA to release any medical information necessary to facilitate payment of said services rendered in the course of treatment.

Signature:______________________________ **DATE:** ____________________

PLEASE COMPLETE OTHER SIDE

CARMEL PEDIATRICS, PA
FINANCIAL POLICY

Thank you for choosing Dr. Dickinson and Carmel Pediatrics, PA as your child's pediatrician. Our primary goal is that you receive proper and optimal care necessary to maintain good health. We hope that you understand that our credit and collection policies are a necessary part of assuring that the financial resources needed to maintain this office for you and the community are preserved. Therefore, we have instituted this Financial Policy. We ask that all responsible parties read and sign our Financial Policy and complete our Patient and Insurance Information form before you can be seen by any physician.

PAYMENT FOR SERVICES ARE DUE AT THE TIME SERVICES ARE RENDERED. We accept cash, checks, and Visa or MasterCard. We are happy to process your insurance claims for any carriers with which we are able to do so. In order to help us complete this task, we ask that you provide us with your current insurance card and any other necessary information that may be needed to file your claim. We may accept assignment of insurance benefits for some carriers. Please understand that although we participate with many insurance carriers, we may not be listed as a member provider with your insurance company. Therefore, please ensure that we are listed as a primary care physician for your insurance company. Problems may arise between you and your insurance company. Therefore, we must inform you of the following:

1. YOUR INSURANCE POLICY IS BETWEEN YOU, YOUR EMPLOYER (WHEN APPLICABLE), AND THE INSURANCE COMPANY. WE ARE NOT A PARTY TO THAT CONTRACT. OUR RELATIONSHIP IS WITH YOU, THE RESPONSIBLE PARTY.
2. All charges are your responsibility whether your insurance company pays or not. All services may not be a covered benefit by your insurance policy. You will be responsible for payment of any uncovered services, any unpaid deductibles, and co-payments at the time services are rendered.
3. In the event that your insurance carrier has not made necessary payment within 30 days, you will be asked to contact the carrier to facilitate the process and to provide any additional information necessary to process your claim.
4. In the event that your insurance carrier has not made necessary payment within 90 days, you will be asked for payment in full by either: cash, cashier's check, money order, Visa or MasterCard.
5. Accounts on which checks have been returned for insufficient funds will have a charge of $25.00 added to the balance. Additional personal checks will then not be accepted for payment.

We understand that temporary financial problems may affect payment of your balance. We are unable to assist you in arranging alternative means of payment unless any such problems are brought to our attention as they are known to you.

Thank you for choosing us as your primary care physician.

I HAVE READ THE FOREGOING FINANCIAL POLICY AND UNDERSTAND IT AND AGREE TO BE BOUND BY ITS TERMS AND CONDITIONS.

Patient Name ____

Responsible Party Signature_________________________________ Date _________________