PATIENT INFORMATION FORM

Patient Information **Date** _____

Name: Last	First	M.I.	Date of Birth
Street Address	City		
State Zip	Home Phone		
Sex	Social Security Number		
Race: ☐ Black, African American ☐ Asian ☐ White ☐ American Indian, Alaska Native ☐ Native Hawaiian, Other Pacific Islander ☐ Unknown ☐ Declined			
Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown ☐ Declined			
Sibling Names (list all):	Date of Birth		

Father's Information ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Name: Last	First	M.I.	
Date of Birth	Social Security Number		
Street Address (if different from child)	City	State	Zip
Home Phone	Cell Phone	E-mail	
Occupation	Employer	Work Number	

Mother's Information ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Name: Last	First	M.I.	
Date of Birth	Social Security Number		
Street Address (if different from child)	City	State	Zip
Home Phone	Cell Phone	E-mail	
Occupation	Employer	Work Number	

Emergency Contact Information

Name	Relationship	Phone

Primary Insurance Information	**Secondary Insurance Information**
Insurance Name	Insurance Name
Name of Subscriber	Name of Subscriber
ID #	ID #
Group #	Group #
Relationship to Patient	Relationship to Patient

Signature of Person Who Filled Out this Form: _____

Who referred you to our practice? _____

AUTHORIZATION TO TREAT A MINOR AND COMMUNICATION OF INFORMATION

I authorize SURF CITY PEDIATRICS to treat my child/children in my absence when under the direct supervision of the following named individuals:

1. _____

2. _____

3. _____

4. _____

5. _____

I give the above individual(s) permission to make medical decisions regarding my child and have my child receive treatment under their supervision. I understand that it is office policy NOT to have my child/children receive vaccinations, however, without a parent or legal custodian present. I also understand that it is in my child's best interest to have a parent or legal custodian be present at all well-child visits/physicals to be able to provide my doctor the most up-to-date and accurate information about my child and be involved as much as possible regarding my child's medical care.

Signature _____

Relationship to Patient _____

Date Signed _____

COMMUNICATION OF INFORMATION

Please indicate your preferences of which phone numbers you wish for us to use to contact you:

(_____) _____ Primary Phone Number

☐ Do ☐ Do Not leave detailed messages on my primary phone number.

(_____) _____ Secondary Phone Number

☐ Do ☐ Do Not leave detailed messages on my secondary phone number.

☐ Do ☐ Do Not send email communications regarding SURF CITY PEDIATRICS announcements.

Signature _____ Date _____

CONSENT FORM FOR FINANCIAL AND OPERATIONS POLICIES STATEMENT

Patient Name_____

Date of Birth _____

Please initial the following requests for authorization:

_____I hereby authorize the physician(s) of Surf City Pediatrics to provide medical treatment to my child/children.

_____I authorize the physician(s) to furnish my insurance company and/or third party payers any medical information necessary to authorize and process insurance claims for payment.

_____I hereby authorize third parties to pay the physician any insurance benefits due for services rendered on behalf of the above named patient.

_____I hereby authorize that I have received, read, and agree to our FINANCIAL AND OPERATIONS STATEMENT and understand that I am ultimately responsible for payments of all medical services.

_____I acknowledge that I am financially responsible for all agreed-upon vaccines that are prepared in the office, even if I change my mind and decide not to have them administered to my child once they have already been prepared.

_____I acknowledge that I have received and reviewed a current copy of "NOTICE OF PRIVACY POLICY" as required by the Privacy Regulations.

_____I understand that after 30 days, any unpaid balance will incur a $15 monthly service fee. This fee is not covered by insurance and therefore will not be billed to insurance.

Signature _____ Relationship to Patient _____

Printed Name _____ Date_____

PATIENT FINANCIAL RESPONSIBILITY

As a courtesy to our patients, we have enrolled in numerous insurance programs. We are pleased to be able to provide this service to you, and we will make every effort to verify coverage and bill your insurance company correctly. However, it is not possible for us to keep track of all the individual requirements of each plan.

It is the responsibility of each patient to know the details of his or her insurance plan in addition to any lapses in insurance coverage. Any changes that occur as a result of insurance plan restrictions or lapses in coverage are ultimately the patient's responsibility. Unfortunately, if you do not inform us of special requirements required by your plan and we order medically necessary services, such as lab work, hospitalization, or supplies that are not covered by your plan; we may bill you directly for those charges. If current insurance coverage cannot be verified prior to each appointment, payment will be due at the time of services.

Providing the highest quality of medical care for our patients is our primary concern. We are more than wiling to provide that care within your insurance plan guidelines, whenever possible. With your cooperation you should be able to receive all of the insurance benefits you are entitled to, and we will be able to focus our efforts on striving to provide you with excellent medical care.

The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for his/her treatment and care. Please initial below that you have read and understand the financial policy of our office.

_____ We are please to assist you by billing for our contracted insurers. However, the patient is required to provide us with the most correct and updated information about their insurance, and will be responsible for any charges incurred if the information provided is not correct or updated.

_____ Patients are responsible for the payment of copays, coinsurance, deductibles, and all other procedures or treatment not covered by their insurance plan. Payment is due at the time of service, and for your convenience, we accept cash, check, and most major credit cards at our office.

_____ I understand that my insurance contract is between my insurance company and me. It is the responsibility of the patient to know and understand their medical insurance benefits. If my insurance has not paid your claim within 60 days from the date insurance was billed, I will be responsible for the payment. I also agree that I am responsible for any charges that my insurance company will not cover. I understand that failure to pay my account or make suitable financial arrangements may result in my account being placed in a state of delinquency. If this becomes necessary, I agree to pay all collection fees, which include but are not limited to collection fees, court fees, attorney fees and any other fees for the collection of my account balance.

_____ I also understand that if I write a check that is returned for any reason, I will be charged a fee, account is sent to collections, there is a possibility that you may be discharged from the practice.

_____ I understand that my insurance will be billed an additional after-hours fee should my child/children be seen during an after-hours visit, including Saturdays. I also understand that I will be financially responsible for this fee should it not be covered by my insurance.

I hereby authorize the physician to release any and all information necessary concerning my diagnosis and treatment for the purposes of securing payment from my insurance company: and there by authorize payment of the insurance benefits directly to the physician for any services rendered that are not paid for directly by me.

A copy of this agreement may be used in place of the original.

Patient or Responsible Party Signature_____ Date _____

Patient Printed Name _____

Responsible Party Printed Name _____

FINANCIAL AND OPERATIONS POLICIES STATEMENT

Welcome to SURF CITY PEDIATRICS! We are very pleased that you have chosen us to be your child's health care provider. We strive to provide the most up-to-date and compassionate pediatric care while minding your child's comfort and earning his or her trust in our fun-loving, kid-friendly office.

Office Visits

We require that any insurance co-pays, deductibles, and any other applicable fees be collected up-front at the time of the office visit.

Insurance Coverage

You must provide documentation of your child's insurance card prior to rendering of services; we also recommend you bring it with you to every visit. Please notify us immediately if there has been an insurance change in order that we may bill accurately and accordingly. It is your ultimate responsibility to know if SURF CITY PEDIATRICS (SCP) is a provider for your insurance company and to understand your insurance policy details, as SCP does not have access to the specifics of your policy. You agree to be personally responsible for the cost of any visit or services if SCP is not the properly contracted provider.

As a courtesy to our patients we will try our best to determine eligibility of your insurance coverage. Positive verification cannot always be obtained due to circumstances beyond our control. If verification of your child's insurance eligibility cannot be determined and you still wish to have your child seen, you will be financially responsible and may be asked to pay for the cost of the visit at the time of service.

HMO Insurance

The physicians of SCP are exclusive providers of only one HMO IPA group: GREATER NEWPORT PHYSICIANS IPA (GNP), provided through Hoag Memorial Hospital. If you have an HMO insurance, in order for your child's treatments to be covered, you must be signed up under one of the physicians in our group. Once signed up, you may see any physician within our group.

If you have coverage with another HMO group other than GNP (such as Monarch, Memorial Care IPA, etc.), your child's treatment will not be covered and you will be held financially liable in the event that we see and treat your child. You should ask one of our staff for assistance.

Newborn Coverage

In general, most newborns are covered under the mother's insurance coverage for the first 30 days. It is very important to arrange to have the baby added to your coverage within the first 30 days to avoid any lapse in coverage. Should you choose an HMO coverage for your newborn and wish to see one of our physicians, you must have the baby assigned to one of our doctors under GREATER NEWPORT PHYSICIANS IPA only, as we are exclusive providers for this HMO group. If you fail to add your baby in a timely manner and there is a gap or lapse in coverage you will be responsible for cash payment for any services rendered.

Outside Services

Please be aware that any services rendered outside of our office (X-rays, laboratory tests, etc.) are billed separately by such outside facilities. Any questions regarding same should be addressed to that facility's billing office. Though we strive to send patients to the most appropriate known facilities for such services depending on the type of insurance plan you may have, it is ultimately your responsibility to be aware of which facilities are contracted with your insurance provider. SCP is not responsible for any out-of-pocket expenses accrued from use of an out-of-network service provider and any other provider other than SCP.

Payment for Services

Payment in full for all services, including vaccinations, is obtained at the time of service for all cash patients and those without confirmed insurance coverage. We accept VISA and MasterCard. A $25.00 fee will be applied to any returned checks or declined credit cards.

Outstanding Balances/Fees

Prior outstanding balances are due and payable prior to receiving future services. To the extent you do not pay amounts owed within 30 days, you will be charged interest at the rate of 1.5% interest per month (or the maximum allowed by law if less) on such past due amount from the date due until paid. You also agree to reimburse SCP for any expenses incurred, including interest and reasonable attorney fees and collection fees and costs, in collecting amounts due to SCP.

Divorce Decree

SCP is not a party to any divorce decree in which you and/or your child may be involved. We require payment and presentation of insurance cards, if any, at the time of service from the accompanying parent.

Miged Appointments and Walk-Ins

Our office works best with scheduled patient appointments. In order for our providers to spend quality time with all of our patients, we ask that you arrive on time for your scheduled appointment. Should you arrive more than 20 minutes late we may ask for you to reschedule.

We may see "walk-in" (same day, not previously scheduled) patients on a very limited basis only. To accommodate such patients, we will try to schedule an appointment based on availability of providers and acuity of symptoms.

We understand that there will be times when an appointment cannot be kept. We request a 24-hour notice to cancel in order to open up an appointment slot for other patients. Failure to do so may result in a missed appointment fee of $25.00.

Forms and Medical Records

We are happy to update any forms, such as school and school physical forms. They will be filled out free-of-charge if we are provided with them on the same date of the visit. There will be a $5.00 charge for school forms provided after the date of the visit. Complicated forms outside of routine school forms will be charged in accordance with physician time spent completing the forms; these may vary. Immunization cards will be provided for a $10.00 fee. Standard medical records copy charge is $25.00, due and payable at the time records are requested.