Millcreek Pediatrics
4512 Kirkwood Hwy Suite 201
Wilmington, DE 19808
Ph: 302 633 6338
Fax: 302 633 9398

Patient Name _____ DOB_____

Attention Parents:

All co-pays are due at the time of visit. If your co-pay is not paid at time of visit we will gladly reschedule your appointment. If your insurance has a deductible or co insurance, you, the patient, are responsible for these charges. Insurance policies are a contract between the patient and the insurer. It is the patient's responsibility to know the benefits of your insurance plan.

There is a $25.00 charge for all patients who do not give at least 24 hours notice to cancel or reschedule their appointment or fail to keep their appointment. If your appointment was scheduled as a consult the fee is $50.00.

There is a $5.00 fee for all forms that are not completed at time of your child's well child appointment. Due to HIPPA regulations we cannot fax any medical information without the parent's/guardian's consent. By signing, dating and providing appropriate fax numbers you are granting our office permission to fax to the designated numbers. We can only mail if the patient provides a self addressed stamped envelope.

What is/are the form/forms that are requested? _____

HOME FAX _____ Initial_____ Date_____
WORK FAX _____ Initial_____ Date_____
SCHOOL FAX _____Initial_____ Date_____
OTHER FAX _____ Initial_____ Date_____
OTHER FAX _____ Initial_____ Date_____

By signing I have read and agree to the above.

SIGNATURE_____ DATE_____

Please fax back to **302-633-9398**