PLEASE COMPLETE THE FOLLOWING ACCOUNT INFORMATION

I. Parent/Guardian_____ Relationship to Child/Children_____
(statement will be addressed to this individual)

Street Address_____ Social Security Number_____ Date of Birth_____

City, State & Zip Code_____ Home Phone Number (_____)_____

Employer_____ Work Phone (_____)_____

Employer Address_____ Cell Phone (_____)_____

City, State & Zip Code_____ ☐ Married ☐ Divorced ☐ Separated ☐ Single

Preferred phone number for messages from our office communication: ☐ Home Number ☐ Cell Number

II. Other Parent/Guardian_____ Relationship to Child/Children_____

Street Address_____ Social Security Number_____ Date of Birth_____

City, State & Zip Code_____ Home Phone Number (_____)_____

Employer_____ Work Phone (_____)_____

Employer Address_____ Cell Phone (_____)_____

City, State & Zip Code_____ Other Parent/Guardian to receive an additional monthly statement? ☐ Yes ☐ No

Preferred phone number for messages from our office communication: ☐ Home Number ☐ Cell Number

III. Primary Insurance_____ Name of Insured_____ Date of Birth_____

Group Number _____ Member ID #_____ Insurance Address_____

Secondary Insurance_____ Name of Insured_____ Date of Birth_____

Group Number _____ Member ID #_____ Insurance Address_____

IV. Emergency Contact _____ Relationship_____ Emergency Phone (_____)_____
(relative or friend that does not live at the same address)

Do we have permission to contact this person regarding matters concerning your care? ☐ Yes ☐ No

V. LIST ALL CHILDREN OLDEST TO YOUNGEST:

First Name_____ Last Name _____

☐ Male ☐ Female Birthdate:_____ Lives with: ☐ Both Parents ☐ Mother ☐ Father ☐ Other:_____

Ethnicity (check one):
☐ Non-Hispanic
☐ Hispanic
☐ Refused to Report

Primary race (check one):
☐ White
☐ Hispanic
☐ African American/Black
☐ Asian
☐ Native American
☐ Native Hawaiian
☐ Other Pacific Islander
☐ Other Race
☐ Unreported/Refused

First Name_____ Last Name _____

☐ Male ☐ Female Birthdate:_____ Lives with: ☐ Both Parents ☐ Mother ☐ Father ☐ Other_____

Ethnicity (check one):
☐ Non-Hispanic
☐ Hispanic
☐ Refused to Report

Primary race (check one):
☐ White
☐ Hispanic
☐ African American/Black
☐ Asian
☐ Native American
☐ Native Hawaiian
☐ Other Pacific Islander
☐ Other Race
☐ Unreported/Refused

First Name_____ Last Name _____

☐ Male ☐ Female Birthdate:_____ Lives with: ☐ Both Parents ☐ Mother ☐ Father ☐ Other:_____

Ethnicity (check one):
☐ Non-Hispanic
☐ Hispanic
☐ Refused to Report

Primary race (check one):
☐ White
☐ Hispanic
☐ African American/Black
☐ Asian
☐ Native American
☐ Native Hawaiian
☐ Other Pacific Islander
☐ Other Race
☐ Unreported/Refused

First Name_____ Last Name _____

☐ Male ☐ Female Birthdate:_____ Lives with: ☐ Both Parents ☐ Mother ☐ Father ☐ Other_____

Ethnicity (check one):
☐ Non-Hispanic
☐ Hispanic
☐ Refused to Report

Primary race (check one):
☐ White
☐ Hispanic
☐ African American/Black
☐ Asian
☐ Native American
☐ Native Hawaiian
☐ Other Pacific Islander
☐ Other Race
☐ Unreported/Refused

(please complete other side)

First Name_____ Last Name _____

☐Male ☐Female Birthdate:_____ Lives with: ☐Both Parents ☐Mother ☐Father ☐Other:_____

Ethnicity (check one):
☐ Non-Hispanic
☐ Hispanic
☐ Refused to Report

Primary race (check one):
☐ White
☐ Hispanic
☐ African American/Black
☐ Asian
☐ Native American
☐ Native Hawaiian
☐ Other Pacific Islander
☐ Other Race
☐ Unreported/Refused

VI. Preferred Pharmacy #1

Name: _____ Address: _____

Phone Number: (____) _____ Mail Order? ☐ Yes ☐ No

Preferred Pharmacy #2

Name: _____ Address: _____

Phone Number: (____) _____ Mail Order? ☐ Yes ☐ No

VII. Name Of Person Who Referred You To Our Practice:_____

VIII. **FINANCE CHARGE INFORMATION**

Balances that are still unpaid 90 days after the insurance has processed the claim are the responsibility of the patient/family and will be subject to a service charge of 1.8% per month (21.6% per year).

annual percentage rate (APR)	**The APR is 21.6%** and applies to statement balances remaining unpaid 90 days from the date denied by insurance
Grace period for repayment of the charge balance	At least 90 days from the date of service. Claims pending with an insurance company with which we have a contract will not begin to accrue interest until 90 days after being denied by insurance.
Method of computing the balance for finance charges	Adjusted Balance Method. Finance charge will be calculated on the balance remaining after payments received during the current period are credited to the outstanding balance at the end of the previous billing period.

I hereby authorize the physician to release information related to medical claims generated from Parkside Pediatrics, S.C. I further authorize payment directly to the physician of benefits due me for his services as described herein. I understand I am financially responsible for charges not covered by this authorization.

Signature: X_____ *Date:*_____
My signature means I agree to the credit terms and conditions that I have been provided in writing.

IX. **EXCHANGE OF ELECTRONIC HEALTH INFORMATION**

ELECTRONIC PRESCRIPTIONS: *Our electronic medical record program accesses your prescription/medication history in order for us to safely prescribe your medication. By signing below, you authorize us to do so.*

Signature: X_____ *Date:* _____

IMMUNIZATIONS: *Our electronic medical record program allows for your immunization data to be sent directly to the I-CARE State of Illinois Registry. I-CARE allows your providers to obtain your immunization history to ensure your safety. By signing below, you authorize us to submit this data.*

Signature: X_____ *Date:* _____

Electronic Medical Records: Our system incorporates a feature, eEHX, that allows the medical records for your family to be viewed by other Health Care Providers (example: specialists). I have been offered the option to review the eEHX pamphlet (a printed copy is available upon request). By signing below, you authorize inclusion in this feature. (If you prefer to have this feature disabled ("OPT OUT"), please notify the Receptionist or one of the office staff to sign an "opt out form.").

Signature: X_____ *Date:* _____
My signature authorizes inclusion in eEHX.

Print Name: X_____

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