PEDIATRIC & ADOLESCENT CARE ASSOCIATES, P.C.

PATIENT INFORMATION

First Name | Middle Name | Last Name | Date of Birth | Gender

Street Address | City | Zip

Home Telephone No. | Cell Number | Work Number

Father's Name | Date of Birth | SSN (Last 4)

Father's employer

Mother's Name | Date of Birth | SSN (Last 4)

Mother's Employer

Emergency Contact | Relationship | Phone No.

Primary Insurance Info. | Subscriber Name

Secondary Insurance Info. | Subscriber Name

e-mail Address | Preferred method for reminder (email/phone)

Please answer these questions:

A: Ethnicity: ☐ Hispanic ☐ Non-Hispanic

B: Preferred Language ☐ English ☐ Other (specify)

C: Race: ☐ White/Caucasian ☐ African-American ☐ Native American
☐ Asian/Indian ☐ Hawaiian/Pacific Isle

AUTHORIZATION TO RELEASE INFORMATION AND ASIGNMENT OF BENEFITS

I authorize the release of any medical information necessary to process my claims. I permit a copy of this authorization to be used in place of the original.

I hereby authorize **PEDIATRIC & ADOLESCENT CARE ASSOCIATES, PC** to apply for benefits on my behalf for covered services rendered by them. I request that payment from my insurance company be made directly to my doctor.

I certify that the insurance information I have reported with regard to my insurance coverage is correct.

I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time, in writing.

Date **Parent/Guardian Signature**

PRIVACY NOTICE

I have been given the opportunity to read the notice of Privacy Practices for Pediatric & Adolescent Care Associates, P.C. and to have a personal copy of the notice.

Childs Name **Parent Signature** **Date**

PATIENT INFORMED CONSENT

INSURANCE PAYMENT POLICY: Payment shall be authorized by the policy holder to be received direct to PACA from various carriers according to appropriate insurance guidelines and provider participation.

PATIENT PAYMENT POLICY: The patient or guarantor shall be responsible for any insurance copays, deductibles, out of pocket expenses or non-benefit services provided, according to appropriate insurance guidelines and provider participation.

NO INSURANCE POLICY: The patient or guarantor is responsible for payment of all services as rendered unless a pre-approved payment plan has been arranged.

BILLING POLICY: Customary and usual billing services are provided at no charge, providing that any information required for billing purposes is accurately presented prior to obtaining services. When incomplete or erroneous information is provided and request for re submission is received, a $15.00 service charge will be applied to facilitate corrective billing services.

NEW PATIENT AND NEW BABY GUIDELINES: I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO MAKE SURE THAT MY CHILD/CHILDREN HAVE BEEN ASSIGNED TO ONE OF THE PHYSICIANS IN THIS OFFICE, OR THAT MY NEW CHILD HAS BEEN ADDED TO MY POLICY AS SOON AS POSSIBLE AFTER BIRTH. I UNDERSTAND THAT IF I DO NOT FOLLOW-THROUGH THAT I MAY BE RESPONSIBLE FOR ALL SERVICES RENDERED UNTIL THEY ARE ON MY CONTRACT.

MASTER MEDICAL RIDERS AND COPAYS: I understand that if I have a Master Medical rider on my BCBSM contract that I am responsible for paying for services at the time they are provided.

FINANCIAL RESPONSIBILITY: I understand that I am responsible to pay for services rendered, including reasonable attorney's fee and costs of collection in the event of default. I further understand that if a payment becomes 60 days past due, delinquency at the lesser of the annual rate of 25% or the maximum allowable rate, will be due on delinquent amounts from the date the payment was due.

ACKNOWLEDGMENT: I HAVE READ, UNDERSTAND AND AGREE TO ABIDE BY THE ABOVE STATED POLICIES.

GUARANTOR SIGNATURE **DATE**