Millcreek Pediatrics
2055 Limestone Rd Suite 300
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.

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 form/forms are being requested? _____

HOME FAX _____ Initial_____ Date_____
WORK FAX _____ Initial_____ Date_____
OTHER FAX _____ Initial_____ Date_____

SCHOOL NAME _____

_____

SCHOOL FAX _____Initial_____ Date_____

Attn: _____

By signing I have read and agree to the above.

SIGNATURE_____ DATE_____