Patient Information

Today's Date __________________

Child's Information

Name ____
First Middle Initial Last

Date of Birth __________________ Gender: M F

Address ____

City ______________________State _____ Zip_________

Emergency Contact - *Other than parents*

Name ____

Phone ____________________ Relationship ____________

School child attends ______________________________

Preferred Pharmacy ______________________________

Race: Am Indian Asian African Am White Other

Ethnicity: Hispanic Latino Other

Please provide us will ALL current insurance information at time of service.

Primary Insurance

Name of Insurance _________________________________
****Please give receptionist your card to be copied**.

Subscriber's Name _________________________________

Birth date of Subscriber __________________ Sex: M F

Relationship to Child ______________________________

Secondary Insurance

Name of Insurance _________________________________
****Please give receptionist your card to be copied**

Subscriber's Name _________________________________

Birth date of Subscriber __________________ Sex: M F

Relationship to Child ______________________________

Mother/Guardian Name _______________________________ Address____
if different than child's address above

Date of Birth ________________________ City ________________________________ State _____ Zip ___________

SS# ______________________ Cell Phone ___________________________ **Can we send you text messages? Y N**

Home Phone ______________________ Employer __________________________________ Work Phone _______________________

Father/Guardian Name _______________________________ Address ____
if different than child's address above

Date of Birth ________________________ City ________________________________ State _____ Zip ___________

SS# ________________________ Phone _________________________ **Can we send you text messages? Y N**

Home Phone _______________________ Employer __________________________________ Work Phone ______________________

Signature _______________________________________ Relationship__________________ Date ________________

Email address ____ @ ________________________________

*** We will use your email address & cell phone to communicate with you regarding your child's appointments.**

We are committed to providing your family with the best possible pediatric care. Your signature at the end of this document will indicate that you have read, understand and agree to the policies outlined below.

BILLING YOUR INSURANCE:

- Please present your current health insurance card(s) at **each** office visit. Our office will bill validated **Primary Insurance** as a courtesy. You must pay for any patient responsibility. If you have **No Insurance,** then payment in full is required at the time of service. It is your responsibility to know your insurance. Fox Pediatrics does not know the terms or conditions of your policy.

PAYMENT FOR SERVICES:

- Co-pays must be paid at the time of service. We mail statements each month. Payment is expected in full within 30 days unless other arrangements have been made. A finance and/or statement fee may be added to unpaid patient balances. We accept cash, checks, money orders, Visa®, MasterCard®, American Express® and debit cards with these credit logos on them.
- **Please initial that you understand our Payment terms above. ___________**

RETURNED CHECKS:

- **The charge for a non-sufficient funds (NSF) check is $30**. You must pay in full for the NSF check and NSF fee within 10 days of notice. If payment is not received by the due date, we will forward the returned check to the District Attorney's office. *It is a felony to knowingly write a bad check*.

COLLECTION ACCOUNTS:

- When an account remains unpaid after 90 days we reserve the option to refer the account to an outside collection agency. We reserve the right to reschedule or deny future appointments for delinquent accounts. If your account is sent to a collection agency you may be asked to find another provider.

LATE ARRIVALS, CANCELLATIONS AND NO SHOWS:

Please arrive 10 minutes prior to your scheduled appointment to allow for timely check-in.

- We require a **24-hour notice** to cancel or reschedule an appointment. For appointments scheduled within 24 hours of the appointment time, a 2-hour notice is required. **If you arrive 10 minutes late to your appointment, you have missed your appointment; therefore, a late cancellation fee will be charged at our discretion.**
- Failure to give proper notice for cancellation or reschedule may result in:
  - **A $25.00 charge for missed appointments or late cancellations, per child**
  - Your family could be subject to dismissal for a third or subsequent missed appointment.
- **Please initial that you understand the policy and fees above. ___________**

***** I acknowledge and understand the office policies and procedures explained above. I hereby authorize my insurance company to pay FOX PEDIATRICS directly. A copy of this authorization can be considered an original for insurance purposes.

***** I do hereby consent to and authorize the performance of all examinations, treatments, and medical services by FOX PEDIATRICS and their staff, which may be deemed advisable. My signature on this document indicates that I have read, understand and agree to the policies outlined in this document.

* I have read the Privacy Notice and understand my rights contained in the notice. By way of my signature, I provide Fox Pediatrics with my authorization and consent to use and disclosed my child's protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

____ ______________

Signature Date

____ _________________________

Print Name Relationship to Child

Updated 1.4.17