PEDIATRIC AND ADOLESCENT HEALTH PARTNERS, P.C.
PATIENT INFORMATION

Patient Name:_____

Nickname:_____ Sex:_____

Date of Birth:_____ Birthplace:_____

Mother's Name:_____

Employer's Name & Address:_____

_____

Occupation:_____ Business Phone:_____

Social Security #:_____ Date of Birth:_____

Father's Name:_____

Employer's Name & Address:_____

_____

Occupation:_____ Business Phone:_____

Social Security #:_____ Date of Birth:_____

Home Address & Telephone #:_____

_____

Billing Address, if Different From Home Address:

_____

_____

Referred By:_____

Insurance Company Name:_____

Subscriber Name:_____ Policy #:_____

Group # and/or Name:_____

Primary Care Physician:_____

Signature:_____ Date_____

*****Please List Names or Patient's Brothers and Sisters*****

_____ _____

_____ _____ (over)

PEDIATRIC AND ADOLESCENT HEALTH PARTNERS, P.C.
CREDIT POLICY

Payment:

Payment for office visits is due in full at the time the service is rendered. Our receptionist is available to discuss our payment policy and your account at the time of the visit.

We accept cash, personal check, Visa, MasterCard and Amercian Express

Insurance:

Responsibility for payment to Pediatric and Adolescent Health Partners, P.C. is your obligation regardless of insurance or other circumstances. However, our office staff is happy to provide any information necessary for you to submit claims to your insurance carrier for reimbursement to you. Insurance claims that are denied, rejected or not paid within 30 days will be your personal obligation. Your help in seeing this claim is paid and satisfied within 30 days is greatly appreciated.

Appointments:

To meet the needs of our families, we see our patients by appointment. From time to time appointments may need to be changed or cancelled. W request that appointments be cancelled as soon as possible prior to the appointment. Appointments that are not kept, and are not cancelled, significantly add to the cost of medical care. Therefore, if you do not cancel an appointment, we must charge you for that visit. The charge will be based on the appointment reason. Unfortunately, this no show fee is not paid for by insurance carriers and will be your full responsibility.

Statements:

Statements are mailed on all outstanding balances each month and are due in full no later than the 25th of the statement month. We reserve the right to impose a finance charge on past due accounts. A 1 ½ % finance charge is imposed on all accounts with non-participation insurances that are 30 days past due. A 1 ½ % finance charge is imposed on accounts of patients with participating insurance companies whose accounts are 90 days past due. Do not ignore statements that you receive. If there is a problem, a clerical error, or an unusual financial situation in your family, which causes difficulty in payment, please discuss it with our business office.

If the account of my child becomes past due and I have not contacted the business office with a payment plan, the account may be forwarded to an attorney for collection. I will then become responsible for reasonable attorney's fees and court costs involved in collection of past due accounts. Should this occur I agree to pay all attorney or collection agency fees (not to exceed 40%) and court costs incurred by Pediatric and Adolescent Health Partners, P.C.

I, the undersigned, agree to accept full financial responsibility for service rendered by Pediatric and Adolescent Health Partners, P.C. I also agree to abide by the conditions outlined in this credit policy.

Date:_____

Signature of Parent or Guardian_____