PINEVILLEPEDIATRICS

PATIENT INFORMATION:

LEGAL NAME(LAST, FIRST, MIDDLE)			Preferred Name
Social Security Number	Sex M F	Date of Birth	Home Phone Number

The child lives with:
____Mother ___ Father ___Grandparent ____ Guardian______________________________

Mother/Guardian's Name			**Father/Guardian's Name**		
Date of Birth	Sex	S.S.N.	Date of Birth	Sex	S.S.N
Street Address(Required)			Street Address(Required)		
City	State	Zip	City	State	Zip
Home Phone	Cell Phone	Work Phone	Home Phone	Cell Phone	Work Phone
Email Address**:**			Email Address:		

Parents: ___Married ____Unmarried ___Separated ___Divorced
Person Responsible for Payment of Bill ___Mother ___Father ___Guardian/Other__________

Employer Name			Employer Name		
Employer Address:			Employer Address:		
City	State	Zip	City	State	Zip

INSURANCE INFORMATION:

PRIMARY			SECONDARY/SUPPLEMENTAL		
Name of Plan			Name of Plan		
Claims Address(Street Address/P.O.Box)			Claims Address(Street Address/P.O.Box)		
City	State	Zip Code	City	State	Zip Code
Phone Number			Phone Number		

PRIMARY		SECONDARY/SUPPLEMENTAL	
Patient Policy Number	Group Number	Patient Policy Number	Group Number
Subscriber Name		Subscriber Name	
Subscriber Sex ____M_____F	Subscriber Policy #	Subscriber Sex ____M _____F	Subscriber Policy #
Guarantor Employer Name		Guarantor Employer Name	
Effective Date	Expiration Date	Effective Date	Expiration Date
Copay Amount $	Relationship to Child	Copay Amount $	Relationship to Child
Plan Type: ___PPO ___HMO ___POS ___Other		Plan Type: ___PPO ___HMO ___POS ___Other	

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EMERGENCY CONTACT: (Other than Mother or Father)		
Name(Last, First, Middle)		Relationship
Home Phone Number	Work Phone Number	Cell Phone Number
How would you like to be contacted regarding appointments, treatment and/or other information pertinent to your healthcare? **____Home Phone _____Work Phone _____Cell Phone _____Email**		
If you have an answering machine, may we leave messages regarding appointments, treatment and/or information pertinent to your healthcare? _____Yes _____No		

Office Policies — PLEASE READ THOROUGHLY

LATE POLICY: IF YOU ARRIVE LATE FOR YOUR APPOINTMENT, WHICH IS 15 MINUTES PAST YOUR APPOINTMENT, YOU WILL HAVE TO RESCHEDULE FOR ANOTHER TIME. THIS WILL ALSO BE CONSIDERED A "NO SHOW" AND THE "NO SHOW" POLICY WILL APPLY.

NO-SHOW POLICY: APPOINTMENTS MUST BE CANCELED 3 HOURS PRIOR TO YOUR APPOINTMENT TIME. IF YOU HAVE "NO SHOWS" WITHOUT CANCELLATION, YOU WILL BE CHARGED A "NO-SHOW" FEE OF $20 FROM OUR CLINIC. AFTER HOUR CALLS TO CANCEL YOUR APPOINTMENT WILL NOT BE ACCEPTED AS SUFFICIENT NOTICE TO CANCEL OR RESCHEDULE YOUR APPOINTMENT. A REMINDER NOTICE WILL BE SENT TO YOU AFTER THE FIRST AND SECOND "NO SHOWS" IN A 12 MONTH PERIOD. DISMISSAL FROM THE PRACTICE WILL OCCUR AFTER THE 3RD "NO SHOW' IN A 12 MONTH PERIOD.

VACCINATION POLICY: VACCINATION RECORDS ARE REQUIRED FOR ALL WELL-CHILD CHECKS AND PHYSICALS.

TRANSFER POLICY: ONCE YOUR CHILD'S RECORDS ARE TRANSFERRED TO ANOTHER CLINIC, HIS/HER FILE WILL BE DEACTIVATED IN OUR SYSTEM AND YOU WILL BE A NEW PATIENT WHEN RETURNED and YOUR PATIENT PORTAL ACCESS WILL BE BLOCKED ON OUR WEBSITE.

I hereby authorize direct payment of surgical/medical benefits to Pineville Pediatrics for services rendered by her in person or under Dr.Jamma's supervision. I understand that I am financially responsible for any balance not covered by my insurance. I authorize Pineville Pediatrics to release information as required to my insurance company or third-party payer for the purpose of determining benefits. I understand that such records may include HIV/AIDS testing, substance and /or mental-health issues. I authorize Pineville Pediatrics to bill my insurance or third-party payer and receive payments directly from insurance for services rendered. I acknowledge full responsibility for the payment of such services and agree to pay my bill in full AT THE TIME OF SERVICE unless other arrangements are made with the financial department. I UNDERSTAND that I remain financially responsible for all charges NOT covered by my insurance company. I authorize the use of this signature on all insurance claims.

I HAVE READ AND REVIEWED A COPY OF THE FINANCIAL POLICY AND NOTICE OF PRIVACY PRACTICES, I UNDERSTAND THEM AND AGREE TO BE BOUND BY THEIR TERMS AND CONDITIONS AND THAT I AM ENTITLED TO RECEIVE A COPY OF SUCH DOCUMENTS.

Parent/Guardian Name: _________________________________Date: ________________

Signature: _______________________________________