Stamford Pediatric Associates, P.C. - Patient Information

Responsible
Billing Party Name:_____DOB_____/_____/_____ Dad or Mom (Please circle)

Home Address:_____City:_____State:_____Zip:_____

Home Phone:_____Cell:_____Soc Sec: _____

Employer:_____ Bus. Phone:_____
Business Address:_____City:_____State:_____Zip:_____

Spouse's Name:_____ DOB _____/_____/_____ Dad or Mom (Please circle)

Home Address:_____City:_____State:_____Zip:_____

Home Phone:_____Cell:_____Soc Sec: _____

Employer:_____ Bus. Phone:_____
Business Address:_____City:_____State:_____Zip:_____

For Emergency Purposes Only please be sure to list any additional biological parents <u>AND</u> any step parents for the children.

Name:_____ Relationship to Child(ren)_____

Home Address:_____City:_____State:_____Zip:_____

Home Phone:_____Cell:_____Bus. Phone:_____Soc Sec: _____

	Children's Names	**Date of Birth**		**Children's Names**	**Date of Birth**
(1)			(2)		
(3)			(4)		
(5)			(6)		

In Case of Emergency Contact (Other than parents)

_____

Name Relationship Phone

Please note the following:

1. All professional services rendered are charged to the Responsible Billing Party. The Responsible Billing Party is responsible for all fees, regardless of insurance coverage. It is also customary to pay for those services when rendered, unless other arrangements have been made in advance with our office bookkeeper.
2. If your account should have to go to collection at any time, you will be charged the collection company's fee along with your outstanding bill amount.
3. A copy of this signature for release of information to your insurance company or referring physician is as valid as the original.
4. By signing this document I am giving express consent for Stamford Pediatric Associates to provide care and treatment to my child(ren).

_____ _____

Signature **Date**

Stamford Pediatric Associates, P.C.

Insurance and Financial Information

The goal of Stamford Pediatric Associates is to provide high quality medical care to our patients. The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services.

Prompt payment allows us to control costs. Payment for services is due at the time services are rendered unless payment arrangements have been approved in advance by our Business Manager. We accept cash, checks, debit cards, MasterCard or Visa.

Returned checks will be charged a $20 fee.

If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. You must realize, however, that:

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.

2. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. **You are responsible for knowing what is and is not covered under your insurance plan.**

3. It is your responsibility to pay for deductibles, co-insurance, copays and any other balance not paid by your insurance company.

4. We do not submit to secondary insurance.

We must emphasize that as child care providers, our relationship is with you not your insurance company. All charges are your responsibility from the date services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, you **must** contact us promptly for assistance in the management of your account.

Financial Policies

If we do not participate with your insurance carrier, payment in full is expected at the time of your visit. You will receive a detailed bill to submit to your insurance company. It is your responsibility to submit this to your insurance company for reimbursement.

Charge Fee - Effective April 2002, a charge fee is an administrative fee of $10 when copay is not paid on the date of visit.

Miss Fee- Effective April 2002, if a physical exam appointment is missed and not canceled within 24 hours your account will be charged $50 per child.

Form Fee- Effective April 1, 2003, you are entitled to one school/camp/daycare form per child per year. Additional forms will require a $5 fee.

PAL Calls- Effective April 1, 2003, each time you use Pediatric Advice Line, a $20 charge will be added to your account and will appear on your monthly statements.

Our practice firmly believes that a good doctor/patient relationship is based upon understanding and open communications. Our staff has been instructed to make every effort to clarify any concerns you may have about your account. If you have any questions concerning our policy or need assistance, please contact us. We are here to help you.

Please complete the registration information on the other side.
Thank You.