North Park Pediatrics, LLC

Patient & Responsible Party Information

Please complete all information & present insurance card & ID at check in.

PATIENT INFORMATION: DOB: ____/____/____ AGE: ____ GENDER: FEMALE / MALE

FIRST NAME: _____ MIDDLE: _____ LAST: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PREFERRED CONTACT#: _____-_____-_____ ( ) CHECK this box if ok to leave a message at this number.

A TEXT REMINDER WILL BE SENT 3 DAYS PRIOR TO APPOINTMENTS. IF YOU WANT TO RECEIVE THIS REMINDER, PLEASE PROVIDE CELL # HERE: _____-_____-_____AND ARRIVE 15 MINUTES PRIOR TO YOUR SCHEDULED TIME.

FATHER / MOTHER / GUARDIAN INFORMATION: DOB: _____/_____/_____ EMPLOYER:_____
(Circle above)
FIRST NAME: _____ MIDDLE: _____ LAST: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

CELL#: _____-_____-_____WORK#: _____-_____-_____ HOME#: _____-_____-_____

FATHER / MOTHER / GUARDIAN INFORMATION: DOB: _____/_____/_____ EMPLOYER:_____
(Circle above)
FIRST NAME: _____ MIDDLE: _____ LAST: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

CELL#: _____-_____-_____WORK#: _____-_____-_____ HOME#: _____-_____-_____

NEW PATIENT? IF YES, PLEASE LET US KNOW HOW YOU WERE REFERRED TO OUR PRACTICE. _____

INSURANCE INFORMATION: INS NAME: _____ POLICY#:_____

GROUP#: _____ INSURED'S NAME: _____ DOB:___/____/____

CO-PAYMENT AMOUNT: $_____ EFFECTIVE DATE: ____/____/____

SECONDARY INSURANCE INFORMATION: INS NAME: _____POLICY#: _____

GROUP#: _____ INSURED'S NAME: _____ DOB:___/____/____

CO-PAYMENT AMOUNT: $_____ EFFECTIVE DATE: ____/____/____

The parent or guardian who brings the child in for care is responsible for payment of the services, this includes payment of the co-pay at the time of service or any additional balances. North Park Pediatrics, LLC will submit claims to the insurance company for services performed. Once a claim is processed, we will bill the patient's responsible party for any balance owed and payment is due upon receipt of that invoice. Any payments more than 60 days late are subject to a $25 late fee each month. It is the responsibility of the parent/guardian to contact their insurance company to resolve open claim issues. Please note that any balance over 120 days late will be forwarded to collections, unless prior arrangements have been agreed upon with the billing department. Secondary insurance submission is the responsibility of the parent/ guardian. Please note that there is a $25.OO fee for missed appointments or those cancelled with less than 24 hour notice. After hour phone calls from your provider are $20.00 if an appointment is not scheduled as a result of the consultation. Your signature below is your agreement to these policies, serves as release of any medical information necessary to process claims for this patient and authorizes payment of medical benefits to North Park Pediatrics.

_____ ____/____/____

Signature of Parent / Subscriber / Guardian Date

_____ ____/____/____

Signature of Parent / Subscriber / Guardian Date

Registration Sheet by Appointment

***My signature** is to confirm that on this date, no information has changed for ____

____ ____/____/____

Signature of Parent / Subscriber / Guardian Date

Staff Initials:_________________ Appointment Time: _____:_____ Arrival Time: _____:_____

***My signature** is to confirm that on this date, no information has changed for ____

____ ____/____/____

Signature of Parent / Subscriber / Guardian Date

Staff Initials:_________________ Appointment Time: _____:_____ Arrival Time: _____:_____

***My signature** is to confirm that on this date, no information has changed for ____

____ ____/____/____

Signature of Parent / Subscriber / Guardian Date

Staff Initials:_________________ Appointment Time: _____:_____ Arrival Time: _____:_____

***My signature** is to confirm that on this date, no information has changed for ____

____ ____/____/____

Signature of Parent / Subscriber / Guardian Date

Staff Initials:_________________ Appointment Time: _____:_____ Arrival Time: _____:_____

***My signature** is to confirm that on this date, no information has changed for____

____ ____/____/____

Signature of Parent / Subscriber / Guardian Date

Staff Initials:_________________ Appointment Time: _____:_____ Arrival Time: _____:_____

***My signature** is to confirm that on this date, no information has changed for____

____ ____/____/____

Signature of Parent / Subscriber / Guardian Date

Staff Initials:_________________ Appointment Time: _____:_____ Arrival Time: _____:_____

***My signature** is to confirm that on this date, no information has changed for____

____ ____/____/____

Signature of Parent / Subscriber / Guardian Date