North Park Pediatrics, LLC

Adult Patient Information Form

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

EMAIL: ____

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.

I AM 18 YEARS OR OLDER AND THE FOLLOWING INFORMATION IS FOR INSURANCE PURPOSES ONLY. I WILL SCHEDULE AND BRING PAYMENT AT TIME OF SERVICE AS NECESSARY. I WILL BE AVAILABLE AT THE NUMBERS PROVIDED ABOVE FOR ALL MEDICAL AND OTHER RELATED MATTERS.

PRIMARY INSURANCE INFORMATION: INS NAME: ________________________________POLICY#: _______________

GROUP#: ____________________________ INSURED'S NAME: ________________________________ DOB:___/____/____

CO-PAYMENT AMOUNT: $__________ EFFECTIVE DATE: ____/____/____ EMPLOYER: ___________________________

SECONDARY INSURANCE INFORMATION: INS NAME: ________________________________POLICY#: _______________

GROUP#: ____________________________ INSURED'S NAME: ________________________________ DOB:___/____/____

CO-PAYMENT AMOUNT: $__________ EFFECTIVE DATE: ____/____/____ EMPLOYER: ___________________________

The patient is responsible for 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 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 patient 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 patient. Please note that there is a $50.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 on the next business day 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 Patient Date

Registration Sheet by Appointment

***My signature** is to confirm that on this date, **NO or SOME** (circle one) information has changed.

____ ____/____/____
Signature of Patient Date

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

****

***My signature** is to confirm that on this date, **NO or SOME** (circle one) information has changed.

____ ____/____/____
Signature of Patient Date

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

****

***My signature** is to confirm that on this date, **NO or SOME** (circle one) information has changed.

____ ____/____/____
Signature of Patient Date

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

****

***My signature** is to confirm that on this date, **NO or SOME** (circle one) information has changed.

____ ____/____/____
Signature of Patient Date

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

****

***My signature** is to confirm that on this date, **NO or SOME** (circle one) information has changed.

____ ____/____/____
Signature of Patient Date

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

North Park Pediatrics, LLC
4C North Avenue, Suite 403
Bel Air, MD 21014

Consent for Release of Confidential Medical Information

Effective date: _____/_____/_____

I authorize North Park Pediatrics to discuss information relevant to my medical care to:

_____ The policy holder of my health insurance for the payment of my bills and claims.

Name: ____________________________ Phone: _____/_____/_____

_____ My parent (s) / guardian(s) for the purpose of my medical care and all related matters.

Name: ____________________________ Phone: _____/_____/_____

Name: ____________________________ Phone: _____/_____/_____

I understand that my records are protected as confidential under federal law and cannot be disclosed without my written consent unless otherwise permitted in accordance with federal law and regulations. I also understand that I may revoke this consent (SEE BELOW) at any time.

Signature: ________________________________ Printed Name: _______________________________

REVOKE OF ABOVE CONSENT

AS OF _____/_____/_____, I REVOKE THE ABOVE CONSENT.

Signature: ________________________________ Printed Name: _______________________________