

Date _____, 2007

The front and back of this form must be completed before we can treat your child

Monthly Newsletter sent by email only. Copies are also available through our Web Site.

Email _____ Account# _____

1ST Patient's Full Name: _____ "Nickname" _____

Birth Date: _____ SSN _____ Sex: _____ OB Doctor: _____

2ND Patient's Full Name: _____ "Nickname": _____

Birth Date: _____ SSN _____ Sex: _____ OB Doctor: _____

3RD Patient's Full Name: _____ "Nickname": _____

Birth Date: _____ SSN _____ Sex: _____ OB Doctor: _____

Father's Name: _____ Phone: () _____ DOB _____ SSN _____
(Last) (First) (Middle) (Area Code)

Father's Address: _____
(No. & Street) (City) (State) (Zip)

Father's Employment: _____ Phone: () _____
(Area Code)

Mother's Name: _____ Phone: () _____ DOB _____ SSN _____
(Last) (First) (Middle) (Area Code)

Mother's Address: _____
(No. & Street) (City) (State) (Zip)

Mother's Employment: _____ Phone: _____

Stepfather/Mother's Name: _____ Phone: () _____
(Last) (First) (Middle) (Area Code)

Stepfather/Mother's Employment: _____ Phone: _____

Primary Insurance Subscriber's Name _____ SSN _____

Policy Identification Number _____ Group Number _____ DOB _____

Secondary Insurance Subscriber's Name _____ SSN _____

Policy Identification Number _____ Group Number _____ DOB _____

Emergency Contacts (Please List Two Who Live Outside Your Home)

Name: _____ Relation: _____ Phone: () _____
(Area Code)

Address: _____
(No. & Street) (City) (State) (Zip)

Name: _____ Relation: _____ Phone: () _____

Address: _____

(No. & Street)

(City)

(State)

(Zip)

Who Has Legal Custody of the Child/Children, and Where Does He/She Reside? _____

Patient Financial Responsibilities:

It is your responsibility to give our office current and up to date information. This includes name, address and telephone number changes, as well as new insurance information.

It is your responsibility to know your insurance plan's policies and guidelines. Every insurance company is different. You should know if your insurance plan's company has a preferred lab or hospital which we are required to use in order for your service to be covered.

It is your responsibility to contact your insurance company to verify that our physician is a participating physician with your insurance company and with your specific plan.

Well checks are covered Yes No

Immunizations are covered Yes No

Save all the EOB forms you receive from the insurance companies. This Explanation Of Benefits form allows you to know why your insurance company has paid as they did. It can serve as the basis for an appeal. It will allow us to help you negotiate with your insurance company. Please study them closely. They are important.

Collection Policies:

After your insurance pays its portion, the remaining balance becomes your responsibility. You will receive 2 monthly statements. If you fail to pay your bill in full or make payment arrangements with us by the date listed on the second statement, your account will then be placed in our collections department. If we do not hear from you, your account will be sent to an outside collection agency. We do accept Visa and MasterCard. Please note that our extended limit for patient due is \$200.00 on an account. We can not exceed this amount and need for all accounts to be kept current.

1. I authorize The Best Kids to initiate and maintain all medical/surgical treatment of my child/children in an emergency or life threatening situation until proper notification can be given and consent obtained.
2. RELEASE OF INFORMATION - I authorize release of any medical information necessary to file any claims to my insurance carrier. This signature or photocopy thereof irrevocably authorizes the release of information necessary to process an insurance claim and further authorizes payment of medical benefits to the physician providing services. *In order to assist you with your insurance company, our office will be glad to submit your claim to your insurance company for you.*
3. I understand that **payment is due at the time services are rendered**. This includes those times when you have not met your deductible, or if you are a self-pay or have an 80/20 type plan and are responsible for a portion of your bill. Copays are paid when you sign in. Delinquent accounts, i.e., accounts with balances due greater than 60 days, will be subject to an interest fee at a monthly periodic rate of 1.5% (equal to an annual percentage rate of 18%).
4. Read and understand Notice of Privacy Practice Acknowledgment.

I, _____ have read / received a copy of The Best Kids Notice of Privacy Practices.
Patient, Parent or Legal Guardian

PARENT/ LEGAL GUARDIAN SIGNATURE _____ SSN _____

PARENT/ LEGAL GUARDIAN SIGNATURE _____ SSN _____