QUINCE ORCHARD PEDIATRICS

Please complete both pages of information

Patient Information

First Name_____**MI**_____**Last Name**_____ ☐**M** ☐**F**

Date of Birth_____

Address_____

City_____**State**_____**Zip Code**_____

Preferred Phone Number_____**Home**_____**Cell**_____**Work**_____

Preferred Email_____

Siblings

Name_____**DOB**_____**M** ☐ **F** ☐ **Name**_____**DOB**_____**M** ☐ **F** ☐

Name_____**DOB**_____**M** ☐ **F** ☐ **Name**_____**DOB**_____**M** ☐ **F** ☐

Parent Information/Responsible Party for this Account

***Please Check*:** ☐**Mother** ☐**Stepmother** ☐**Father** ☐**Stepfather** ☐**Legal Guardian** **Marital Status:** ☐**Single** ☐**Married**

First Name_____**MI**_____**Last Name**_____

Address_____**City**_____**State**_____**Zip**_____

Phone (Home)_____**(Work)**_____**(Cell)** _____**Date of Birth**_____

Please Check: ☐**Mother** ☐**Stepmother** ☐**Father** ☐**Stepfather** ☐**Legal Guardian** **Marital Status:** ☐**Single** ☐**Married**

First Name_____**MI**_____**Last Name**_____

Address_____**City**_____**State**_____**Zip**_____

Phone (Home)_____**(Work)**_____**(Cell)**_____**Date of Birth**_____

Primary Insurance

Subscriber's Name_____

Subscriber's Date of Birth_____

Address_____

_____

Phone Number_____

_____

Insurance Company_____

Policy #_____**Group#**_____

Secondary Insurance

Subscriber's Name_____

Subscriber's Date of Birth_____

Address_____

_____

Phone Number_____

Insurance Company_____

Policy #_____**Group#**_____

Patient Demographic Information

(Check One)

☐**American Indian/Alaska Native**

☐**Asian**

☐**Native Hawaiian or Other Pacific Islander**

☐**Black or African American**

☐**White**

☐**Hispanic**

☐**Other Race**

☐**Decline to Report**

Pharmacy Information

PHARMACY NAME:_____

ADDRESS:_____

_____

PHONE:_____

FAX:_____

QUINCE ORCHARD PEDIATRICS

Consent

I, _____, as Parent/Legal Guardian, give consent to the staff of Quince Orchard Pediatrics examine, treat, and/or care for my child_____.

In the event that I or other legal guardian of my child am/is not able to bring said child in to the office, the following person(s) have my consent to bring them in for medical care.

	Name	Relationship	Phone
1			
2			
3			

Emergency Contact

Name_____Relationship_____

Phone Number_____

Policy Concerning Payment of Medical Bills

1. Copayments are due at the time of service.
2. There is a $5 billing fee for all copayments not collected at the time of service.
3. Whether or not your insurance pays in full, a portion, or nothing at all for services rendered, is a matter between you and your insurance carrier.
4. Any unpaid balance is due within 30 days of treatment date, unless other arrangements have been made.
5. Finance charges at the rate of 1.5% per month will be assessed for all patient balances not paid within 30 days.
6. Payment is accepted in the form of cash, check, money order, Visa, Mastercard, or Discover.
7. There is a $35 charge for all returned checks.
8. If you need to cancel an appointment, please call the office at least 24 hours in advance. There is a $25 charge for all missed appointments and appointments cancelled less than 24 hours in advance.
9. If you are more than 15 minutes late for your scheduled appointment we cannot guarantee that you will be seen at that time and you may be charged $25 for the missed appointment.
10. If you have any questions regarding these policies, please ask to speak to our Billing Specialist or Manager.

*I, _____, hereby authorize Quince Orchard Pediatrics to apply for benefits on minor's behalf for covered services as rendered. I request payment be made directly to Quince Orchard Pediatrics. I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or, any related claim to the above named billing agent. I permit a copy of this authorization to be used in place of the original. Either the above-named carrier or I may revoke this authorization at any time in writing. I agree to be legally responsible for any and all charges incurred for the patient named below. I certify that all the information provided is correct.

I have read and been offered a copy of the Notice of Privacy Practices for this office.

_____ _____

* Signature of Subscriber/Beneficiary Date