UPDATE INFORMATION

Today's Date _____

PLEASE PRINT:

Patient's Full Name _____S.S. No. _____ Birthdate _____

Present Street Address _____ Apt. _____

City_____State/Zip Code _____Telephone _____ Sex _____

Parent/Guardian 1: _____ Birthdate _____ Occupation _____

S.S. No. _____ Driver's License State & No. _____ Cell phone _____

Employer (company) _____ Phone _____

Parent/Guardian 2: _____ Birthdate _____ Occupation _____

S.S. No._____ Driver's License State & No. _____ Cell phone _____

Employer (company name) _____ Phone_____

In Case of Emergency Notify (other than parents listed above) _____ Phone _____

Legal Guardian (Custodial Parent) _____ Address _____

Current email address _____

SOCIAL HISTORY

Parents are: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Child lives with: ☐ Parents in own home

☐ Parent somewhere else (Who) (Where?) _____

☐ Someone else (Who?) _____

Anything else that we need to know about your family? _____

_____

PRIMARY INSURANCE

Name of Insurance Co. _____ I.D.No. _____ Group No. _____

Name of Insured (as it appears on card) _____

Through place of Employment ☐ Yes ☐ No Where? _____

SECONDARY INSURANCE

Name of Insurance Co. _____ I.D.No. _____ Group No. _____

Name of Insured (as it appears on card) _____

Through place of Employment ☐ Yes ☐ No Where? _____

(PLEASE COMPLETE OTHER SIDE)

Palmetto Pediatrics, PA
Office Financial Policy

In order to reduce misunderstanding between our patients and our practice we have adopted the following financial policy. If you have any questions, please discuss them with our medical assistants or office manager. We are dedicated to providing the best possible medical care and service to you and your children and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

Unless other arrangements have been made in advance by either you or your health coverage carrier, full payment is due for office visits at the time of service. For your convenience we also accept MasterCard, Visa or Discover Card.

We have prior arrangements with some insurance companies and health plans to accept payment from them and to file claims for your care. If you have one of these coverages, you will only have to pay the authorized copayment or deductible at the time of service.

If you have any other type of health insurance (that we do not have a prior agreement with), we will provide you with an itemized statement for you to file for reimbursement. The charges for your office care are due at the time of service.

For hospital and emergency room care, we will file with most insurance carriers.

Medicaid Patients

You must show a current Medicaid card at each visit. If you do not have your card you will be expected to pay at the time of visit.

Other Billing Information

A $20.00 fee is added to the office visit if your part is not paid in full at the time of visit. A $3.00 per month fee for the cost of billing will be added for each month that we have to send you a bill. The parent that accompanies a child for medical care, as well as the custodial parent or guardian is responsible for paying for that care unless other arrangements are made in advance. We will be glad to tell you in advance an estimated charge for any service, but the service may vary depending on what the doctor is required to do. In the event your health plan determines a service to be “not covered”, you will be responsible for the complete charge.

All charges are due regardless of insurance coverage after 60 days. You are responsible for all charges incurred.

I have read and understand the financial policy of the practice, and agree to be bound by its terms. I authorize the release of medical information and request payment of benefits to Palmetto Pediatrics, PA. This agreement applies to all patients for whom, under the terms of this agreement, I am responsible.

Notice of Privacy Practices Patient Acknowledgement

I have received this practice’s Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice’s legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, This practice. I understand I can obtain this practice’s current Notice of Privacy Practices on request.

Signature: _____ Date: _____

_____

Relationship to patient (if signed by a personal representative of patient)