

Patient Name: (Last) _____ (First) _____ (Initial) _____

Street Address : _____ (City) _____ (State) _____ (Zip) _____

Sex: _____ Age: _____ Date of Birth: _____ Social Security # _____

Home Telephone: # _____ Alternate Telephone: # _____ work mobile

INSURANCE INFORMATION Please provide information for the insured/person who provides the coverage

Primary Insurance Carrier: _____ Effective Date: _____

Policy # _____ Group # _____

Policyholder Name: _____ Policyholder D.O.B. _____

Policyholder S.S.# _____ Policyholder Employer: _____

Relationship to Patient: _____ Is this a PPO/HMO/POS? _____

Payment is expected at the time of service. If we are a participating provider in your insurance plan, you must present a valid insurance card at the time of service or be responsible for payment in full. If a current ID card is not presented prior to the visit the patient will not be eligible for any benefits of the plan.

Signature of Parent/Guardian: Date: _____

Give information for the PARENT/LEGAL GUARDIAN who is accompanying child to this visit

Name: _____ Relationship to Patient: _____

Address: _____ (City) _____ (State) _____ (Zip) _____

Telephone # (home) _____ Alternate Telephone: # _____ work mobile

I warrant that I am the party responsible for making medical decisions for the child represented in this medical record. I acknowledge that payment is due at the time of service, unless other arrangements have been made. I assume financial responsibility for any and all healthcare services provided to this patient. I understand that Willow Bend Pediatrics will not get involved in matters involving third party personal billing whether result of custody, court order or personal circumstances. The parent/guardian accompanying the child to the visit is responsible for any payment due at the time services are rendered.

Signature of Parent/Guardian (as identified above): Date: _____

Social Security #: _____ DOB: _____

Siblings

Name: _____

Date of Birth: _____

Name: _____

Date of Birth: _____

Name: _____

Date of Birth: _____

Patient of WB Pediatrics

Yes No

Yes No

Yes No

Patient Name: _____

Consent to Treatment: I hereby give my consent for medical treatment by the physicians or under the direction of the physicians of Willow Bend Pediatrics

Parent or Guardian Signature

_____ Date

Consent for Treatment - Accompanied by Other than Parent or Legal Guardian: I hereby give my consent to the rendering of both emergency and non-emergency healthcare services by the Physician out of my physical presence, and the performance of all necessary diagnostic tests when the individual listed below accompanies my child to the office:

Authorized Individual _____ Relationship to Patient _____

Parent or Guardian Signature

_____ Date

Payment Policy: I understand that I am responsible for payment of professional services at the time they are rendered. I understand that I am responsible for any amount not covered by insurance including, without limitation, deductible, co-payment, co-insurance, or other amounts unpaid by my insurance, if benefits assigned. Willow Bend Pediatrics files claims for any of the Managed Care Plans with which we participate. Claims will not be filed with other insurance carriers. If you Plan to pay by check and it is dishonored a processing fee of \$15 will be assessed

Parent or Guardian Signature

_____ Date

Assignment of Benefits: I assign to Willow Bend Pediatrics all payments for medical services rendered to my dependents for services filed to insurance on my behalf.

Parent or Guardian Signature

_____ Date

Authorization for Release of Medical Information: I hereby authorize Willow Bend Pediatrics to release any medical or incidental information that may be necessary for medical care or to process medical insurance claims for which payment is assigned to the provider.

Parent or Guardian Signature

_____ Date

I authorize that messages may be left for the patient about appointment reminders or instructions regarding patient care:

At Parent's work Initial _____ On home answering machine Initial _____ With other family member Initial _____

I may revoke consent for any or all of the above initialed items at any time in writing. I certify that all information provided to Willow Bend Pediatrics is correct.

Parent or Guardian Signature

_____ Date