HOPE PEDIATRICS

PATIENT: ______________________ **Male or Female** **DATE OF BIRTH:** ________________

Address: ______________________ **Telephone:** ________________________

______________________ **School:** ________________________

SS# ______________________ **Church Affiliation:** ________________________

FATHER: ______________________ **Date of Birth:** ________ **SS#** ____________

Address: ______________________ **Telephone:** ________ **Cellphone:** ____________

______________________ **Employer:** ________________________

______________________ **Work Telephone:** ________________________

MOTHER: ______________________ **Date of Birth:** ________ **SS#** ____________

Address: ______________________ **Telephone:** ________ **Cellphone:** ____________

______________________ **Employer:** ________________________

______________________ **Work Telephone:** ________________________

EMERGENCY CONTACT: ______________ **Telephone:** ________________________

DENTIST: ______________________ **Telephone:** ________________________

NEAREST RELATIVE (not living with you) ______________ **Telephone:** ________________

Password: __________ **(five letters or numbers) (Optional – to be used to release information about your child over the telephone). If you are concerned about the privacy of your child's health information, you can elect to use a unique password, otherwise your child's date of birth will be asked before releasing information over the telephone.**

INSURANCE AND BILLING

Primary Ins. Co.: ______________________ **Subscriber:** ________________________

ID: ______________________ **Group:** ________________________

Secondary Ins. Co.: ______________________ **Subscriber:** ________________________

ID: ______________________ **Group:** ________________________

We participate with the following insurance companies: Health America, Highmark BC/BS, SelectBlue, Keystone, PremierBlue, DirectBlue, Medical Assistance, Cigna, Aetna, UPMC for You, UPMC and Vantage. We do not participate with Community Blue. If you have any other insurance, we will submit a claim for you; however, you will be responsible for payment at the time of service. We do not participate or send claims to major medical. You are responsible for payment at the time of service. We will provide you with an itemized statement. Any deductible, co-pay and/or co-insurance will be collected at the time of service. An additional charge of $10.00 will be added to all co-pays not paid at the time of service.

There will be a $10 charge for any returned checks. There will also be a $10 charge for any accounts turned over for collection services.

ASSIGNMENT OF INSURANCE INFORMATION

I hereby authorize direct payment of surgical/medical benefits to HOPE PEDIATRICS for services rendered by the doctor(s) in person or under his/her supervision. I understand that I am financially responsible for any balance not covered by my insurance. I authorize HOPE PEDIATRICS to file a formal complaint with my insurance and/or the insurance commissioner on my behalf in order to collect payment for services

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize HOPE PEDIATRICS, to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefits.

I certify that the information given by me in applying for payment is correct. I request that payment of authorized benefits be made on my behalf.

I further certify that my signature below represents that I have read and understand the above information regarding insurances, co-pays and additional charges that may be assessed.

Parent/Guardian or other authority (please print)____

Signature:____________________________________ **Date:**____________________