Westchester Park Pediatrics

Registration: **Date**: ________________________________

Patient First name:____Last:_____________________________________

DOB:____________________________ Gender: Male _____ Female ______ Prefers Not to Answer________

Parent/Guardian: ____ Cell (_____)_____________________

Parent/Guardian: ____ Cell (_____)_____________________

Patient's Home Address: ____

City: _____________________________________ State: _________________________ Zip code: ______________

Billing Address (*if different from above):* ____

City: _____________________________________ State: _________________________ Zip code: ______________

Home Tel # (______)________________________Preferred Email: ____

Insurance Information:

Primary Insurance Plan Name: ____
Policy Number: __________________________________ Group Number: ___________________________________
Primary Policy Holders Name:____ DOB: _____________
Relationship to Patient: ___________________ Employer: ____

Responsible Party:

Name ____ Phone/Cell (______)_____________________

Release of Information and Assignment of Benefits
I hereby authorize *Westchester Park Pediatrics, PLLC* to release information concerning treatment or services rendered to Medicare and other insurance carriers responsible for my or my dependent's care. I request that payment of authorized Medicare and other insurance company benefits be made to me or on my behalf to Westchester Park Pediatrics, PLLC for all services rendered. I have been advised that if my insurance requires a co-pay, it is due at the time of the visit to avoid a late fee of $20 added to my bill.

Signature of Parent /Guardian____ Date: _____________

Financial Policy

Thank you for choosing Westchester Park Pediatrics as your child's health care provider. Please be assured that your child's health care is of the utmost importance to us. Your clear understanding of our Financial Policy is important to our professional relationship with you. This policy will serve as a guide to our policies and help with any questions about your financial obligations.

Insurance

Westchester Park Pediatrics participates with most insurance plans. To properly bill your insurance company, we require a copy of your (or your dependent's) insurance card. It is your responsibility to inform us of as any change of insurance. Failure to provide complete insurance information may result in patient-responsibility for the entire bill.

Co-Payments

Contractional obligation with your insurance plan requires us to collect a co-payment. All co-payments will be requested at the time of the service. There will be a $20 surcharge applied to your account if your co-pay is not paid at the time of service. We accept cash, credit cards or check. There is a $50 fee for any check returned to us from your banking institution.

Self-Pay

Payment is expected at the time of the visit unless other arrangements have been made with the office manager prior to the visit. We accept cash, credit cards or check. There is a $50 fee for any check returned to us from your banking institution.

Non-covered Service

We will always provide your child with what we consider medically necessary based on the guidelines of the AAP. As a result, certain services provided to your child may not be reimbursed by your plan. These services will be the responsibility of the policy holder/parent.

No Show/Late Cancel Policy

A $75 surcharge will be applied to your account if you (your dependent) do not arrive for an appointment and do not cancel 24hrs prior to the scheduled appointment.

Laboratory Services

We will send your lab work to the preferred laboratory based on the insurance information you have provided to our office. We are not responsible for balances due from outside labs. These services will be the responsibility of the policy holder/parent.

Camp/School Forms

There will be a $10 charge for any forms. You can request a NY State Health Appraisal form at no cost.

I acknowledge full responsibility for services rendered by Westchester Park Pediatrics, PLLC. I understand that I am responsible for prompt payment of any portion of the charges not covered by insurance. I understand that co-pays are due at time of check-in; otherwise the applicable co-pay charge will be applied to my account.
I authorize Westchester Park Pediatrics to release information to Medicare/other insurance carriers responsible for my dependent's care. I request that payment of authorized Medicare other insurance company benefits be made either to me or my behalf to Westchester Park Pediatrics for any service rendered.
I,______________________________ understand that it is my responsibility to select Dr. Avvocato, Dr. Chen, Dr. Kelleher, Dr. Woo or Dr. Wurzel.

Signature of Parent /Guardian____ Date: ____________
SW:10.19