SOUTHFIELD PEDIATRIC PHYSICIANS, PC. Acct#:__________________

Patient Information Form

Patient's Name:____ □ male □ female DOB:_______________

Father/Guardian's Name	**Mother/Guardian's Name**
____	____
Last First	Last First
Birthdate:_________________________________	Birthdate:_________________________________
Social Security#___________________________	Social Security #___________________________
Address:__________________________________	Address:__________________________________
Apt/Bldg#________City:____________________	Apt/Bldg#________City:____________________
State____________Zip______________________	State____________Zip______________________
Home Phone: (______)______________________	Home Phone: (______)______________________
Cell Phone: (______)_______________________	Cell Phone: (______)_______________________
Employer:_________________________________	Employer:_________________________________
Work Phone: (______)______________________	Work Phone: (______)______________________

Email Address:____

EMERGENCY Contact Other than Parent__________________________Relationship to child___________________________

Phone ______________________ Alternate: __________________________

We will bill your insurance only if we participate with that company. You are responsible for any and all charges that your insurance company does not cover for any reason, including all HMO's. ***ALL payments and copays are due at the time of service.*** *The person who brings the child or children in is responsible for payment. Our office will not accept responsibility for a disputed claim and all bills are to be paid upon receipt of your statement. Copays not paid at time of service will incur a $5 statement fee and repeated failure to pay would be considered for possible patient dismissal. I authorize insurance payment for all medical care to be made to Southfield Pediatric Physician, PC.*

1. Insurance Name ____Subscriber________________________

2. Insurance Name ____Subscriber________________________

If your child/ren is/are insured by multiple insurances they must **all** be presented **prior** to receiving services. Failure to provide this information will result in my financial responsibility for those services regardless of coverage.

Sibling's Full Names – First M. Last

1.____birthdate_______________________ M F

2.____birthdate_______________________ M F

3.____birthdate_______________________ M F

4.____birthdate_______________________ M F

please continue on back if more than 4 children

Signature_X____ Date_________________________

CONSENT TO EXAMINE AND TREAT A MINOR

1. I, ______________________________________, do hereby consent and authorize Southfield Pediatric Physicians, and/or such associates, assistants or designees as may be selected by him/her, to examine

   and treat my child/children:____

   ____
2. I affirm that I have the legal right to consent to this.
3. This consent is binding until specifically revoked by myself or another person who has the right to sign or revoke this form.
4. I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me as to the results of examinations and treatments.
5. I give the physicians of Southfield Pediatric Physicians permission to treat my child in my absence in case of emergency or when accompanied by a designated representative.

PAYMENT POLICIES

I understand and promise payment of all copays, deductibles and non-covered services and agree to payment at time of service; and understand that this is a contingency of our continued patient/physician relationship.

Insurances/HMO/POS/PPO
I understand that due to the uncertainty of eligibility and/or primary care physician assignment, that **if denied by insurance for services or treatment for myself, or my dependents, I am financially responsible for all balances.** This includes all HMO plans (*Aetna, HAP, BCN, Cofinity, Cigna, United Health, Molina, PHCS, United Health, and/or any other insurance companies not stated)*. I understand that the assignment of a Primary Care Physician to a Southfield Pediatric Physician for my dependents is my responsibility. Any visits without authorization from that Primary Care Physician are at my expense and will be paid at time of service.

I authorize for insurance payments to go directly to the physician and for the release of any and all medical information contained in the medical record as requested by the insurance company in determining benefits.

Financial Obligation
I understand that Southfield Pediatric Physicians or their associates will not become involved in disputes of parental/guardian medical financial liability. The parent requesting services is responsible for any and all financial obligations. Any previous agreements legal or otherwise between the parties will be resolved between the parental/guardian parties and will in no way effect timely payment of the patients account.

Newborn
I understand that it is my responsibility to contact my insurance to have my newborn child added to my insurance within the first week of birth. I understand that failure to do so may jeopardize my child's ability to be insured. I will provide Southfield Pediatrics with my child's health care coverage information as soon as the policy is effective to assure timely billing. Failure to do so will result in non-covered services by my insurance to which
I am responsible for and guarantee payment.

In agreeing to have my child/children treated by Southfield Pediatrics Physicians I agree to all terms, policies and conditions set forth by Southfield Pediatric Physicians, whether stated or unstated.

PRIVACY PRACTICES ACKNOWLEDGEMENT (posted in waiting room)
I understand the Notice of Privacy Practices and I have been provided an opportunity to review it.

X____ ____________________
Signature of Parent/Legal Guardian Date

No Show Appointment Fee Policy

Child's Name:_______________________________ Acct#:_______________

Effective July 23, 2007, Patients that no show 3 times within a 6 month period will be discharged from the practice and a notification will be sent to your insurance company.

This policy is being put into effect due to the recent increase in patients not showing for their scheduled appointments. When patients do not show for their scheduled appointments this decreases the amount of care we can provide for other patients in need.

By signing below, I am indicating that I understand this policy.
Appointments can be canceled 24 hours a day 7 days a week by calling the office or logging on to the patient portal on our website www.southfieldpeds.com and sending us a message.

____ ____________

Signature of patient/parent/guardian Date

Southfield Pediatric Physicians, PC
Financial Policy
Please keep for your records.

We bill your insurance company as a courtesy.

Your are responsible for the entire bill if your insurance company does not recognize you or your child as active on the account, rejects the claim or fails to process the claim.

Know what your insurance company covers. The doctor orders tests and procedures based on your child's needs. Based on your insurance contract, some procedures may not be covered 100%.

Failure to provide accurate insurance, address and phone number information will result in you receiving and being responsible for your bill.

I, hereby authorize my insurance benefits to be paid directly to Southfield Pediatric Physicians, realizing I am responsible to pay non-covered services, co-pays, co-insurance and deductibles and I hereby authorize the release of pertinent medical information to insurance carriers. I have reviewed my demographic and insurance information for any errors.

If at anytime you are unable to pay your bill please contact the office immediately. We send out two statements 30 days apart. After the second statement, if a payments has not been made or a payment plan has not been established your account will be forward to collections. **Do not wait to contact us**. We understand times are challenging and we will do our best to work with you to set up a payment plan and prevent collection activity.