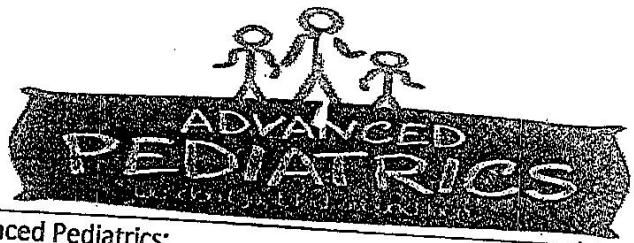

How did you Hear about Advanced Pediatrics:

IF PARENTS ARE DIVORCED, PLEASE FILL OUT THIS SECTION:

*Who has custody?*_____

Are there any legal restrictions that would restrict the non-custodial parent from authorizing medical treatment for the child or from obtaining information about the child's medical treatment? Yes/No

If yes, please explain and provide a copy of the legal paperwork that supports this restriction.

INSURANCE INFO:

Primary insured:

Ss# Ins Co: Relationship to Patient:

Insurance Claims Address: Policy # Group#

Emergency Contact: Relationship: Phone:

Other children:

Name:

Name: Date of birth:

Name: Date of birth:

Date of birth:

YOU ARE FINANCIALLY RESPONSIBLE FOR ALL CHARGES INCURRED, REGARDLESS OF IKNSURANCE COVERAGE! PLEASE READ THE FOLLOWING CAREFULLY! BY SIGNING BELOW, YOU INDICATE YOU UNDERSTANDING AND ACCEPPTANCE OF THE FOLLOWING POLICIES:

1. **I authorize the release of any medical or other information necessary to process my insurance claims. I authorize the release of medical records for the purpose of medical referrals, and to the persons listed above.**
2. **I authorize the release of medical information to schools, camps, or other programs after my written or verbal request.**
3. **I have received and read the HIPAA policy of Advanced Pediatrics.**
4. **I authorize payment of medical benefits from my insurance company or government program to Advanced Pediatrics.**
5. **I agree to pay all insurance copays and/or coinsurance at the time of check-in and prior to services being rendered.**
6. **If Advanced Pediatrics cannot verify my insurance at the time of visit, or if I do not bring current proof of insurance to each visit, I agree to pay charges in full before the patient is seen.**
7. **If any charges incurred by me or my dependents are submitted to a collection agency, I agree to pay all fess including, but not limited to, both the collection agency fee and the account balance.**
8. **If I miss any appointments without prior notification to this office, I agree to pay $25.00 no show charge.**
9. **I agree to pay a $25.00 charge, in addition to the check amount, on any of my personal checks which are returned to this office by my bank.**
10. **While you appointment may be for a specific time, no express or implied guarantee is made that a nurse or physician will see you at that exact time. Advanced Pediatrics makes every effort to see patients in a timely fashion, subject to patient volume and emergencies beyond our control. I agree to not hold Advanced Pediatrics responsible in any manner for time spent waiting to be seen.**
11. **I understand that Advanced Pediatrics bills insurance as a courtesy. I understand that my financial charges for services rendered by Advanced Pediatrics are ultimately my responsibility.**

Responsible Party (Print Name):

Signature of responsible party

Date: