Associates in Pediatrics, S.C.

already owner but should put on insurance + other site

Patient Information Sheet **Today's Date:** _____

First name: _____ Middle initial: _____ Last name: _____ Sex: ☐M ☐F

Date of Birth: _____ E-mail address: _____

Address: _____
ADDRESS CITY STATE ZIP

Primary phone: _____ Secondary phone: _____ Work: _____

Mother _____ Date of Birth _____ Father _____ Date of Birth _____

Responsible Party: Mother / Father (Circle one) SSN: _____

Responsible Party Address: _____
Address City State Zip

Insurance: _____ Who holds insurance policy? _____

Emergency contact: _____ Relationship: _____
NAME PHONE NUMBER

Do we have permission to contact this person regarding matters concerning your care? ☐ Yes ☐ No

Referred by: _____

Ethnicity (check one):
- ☐ Non-Hispanic
- ☐ Hispanic
- ☐ Refused to Report

Primary race (check one):
- ☐ White
- ☐ Hispanic
- ☐ African American/Black
- ☐ Asian
- ☐ Native American
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ Other Race
- ☐ Unreported/Refused

Preferred Language (check one): ☐ English ☐ Spanish ☐ Other: _____ Interpreter Needed? ☐Yes ☐No

Preferred Pharmacy #1: _____ Mail Order? ☐ Yes ☐ No
NAME ADDRESS PHONE NUMBER

Preferred Pharmacy #2: _____ Mail Order? ☐ Yes ☐ No
NAME ADDRESS PHONE NUMBER

ELECTRONIC PRESCRIPTIONS: *Our electronic medical record program accesses your prescription/medication history in order for us to safely prescribe your medication. By signing this, you authorize us to do so.*

IMMUNIZATIONS: *Our electronic medical record program allows for your immunization data to be sent directly to the I-CARE State of Illinois Registry. I-CARE allows your providers to obtain your immunization history to ensure your safety. By signing this, you authorize us to submit this data.*

Signature: _____ *Date:* _____
PATIENT/GUARDIAN RELATIONSHIP TO PATIENT

I have been given a copy of Associates in Pediatrics' Notice of Privacy Practices, which describes how my health information is used and shared. I understand that Associates in Pediatrics has the right to change this Notice at any time. I may obtain a current copy by Contacting the Facility Privacy Official, or by visiting the Associates in Pediatrics website at www.aipdocs.com

My signature below acknowledges that I have been provided with a copy of the Notice of Privacy Practices

_____
Signature or Patient or Guardian **Date**

Please flip over, and fill out second half

Associates in Pediatrics, S.C.

Billing Policy

Our goal is to provide and maintain a good physician patient relationship. Letting you know in advance our billing policy allows for a good flow of communication and enables us to achieve our goal. If you have any questions, do not hesitate to ask a member of our staff.

Appointments

We value the time we have set aside to see and treat your child. If you are unable to keep your appointment, we would appreciate a 24-hour notice. There will be a charge of $25.00 for missed appointments.

Insurance Plans

1. It is your responsibility to keep us updated on your correct insurance information. If the insurance information you give us is incorrect, you will be responsible for payment of the visit.
2. It is your responsibility to understand your benefit plan. If a service is provided that is not covered by your insurance, you will be the responsible party. For example
    a. Not all plans cover annual healthy (well) physicals, sports physicals, or hearing and vision screenings.
    b. For children younger than 2 years, there is a limit as to the number of well visits per year. If the number of well visits is exceeded your insurance will not pay
3. If we have not received payment from your insurance company within the contracted time frame, you will be responsible for the balance due. In special cases, we may need your help in contacting the insurance for payment of your service.

Telephone calls after hours

Telephone calls made to a physician after business hours will result in a $25.00 fee to the patient upon return of your telephone call by the physician.

Financial Responsibility

1) According to your insurance plan, you are responsible for all co-payments
2) deductibles, and coinsurances.
3) Co-pays are due at the time of service
4) Every month our office sends out statements. The balance due is the remainder owed after your insurance has paid. It is your responsibility to pay your monthly statement each month even if you and your insurance company are disputing coverage.
5) We offer payment plans to our patients, if needed. If you fail to make your monthly payments your account will be sent to collections.
6) All over-due patient balances will be sent to collection.
7) Self Pay patients, if you do not have insurance your balance is do at the time of your office visit.

WE ACCEPT CASH, MASTERCARD, VISA, DISCOVER, AMEX, DEBIT AND CHECKS

I hereby authorize AIP to release all medical information to insurance carrier and or Medicaid concerning my illness and treatment and I hereby assign payment to AIP for services to myself/dependent. I understand I AM RESPOSIBILE FOR ANY AMOUNTS NOT COVERED BY INSURANCE.

Patient Name_____

Responsible Party Name _____Relationship_____

Responsible Party Signature _____Date_____