PEDIATRIC SURGERY, P.A.
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PLEASE FILL OUT THIS FORM COMPLETELY – BOTH PAGES –
PLEASE ASK US IF YOU HAVE ANY QUESTIONS. THANK YOU!

Chart#: _____ Date: _____

YOUR CHILD

Child's Name: _____ Nickname: _____

Sex: Male / Female Date of Birth: _____ Soc. Sec.#: _____

Home Phone: _____

Address: _____
(Street) (Apt. #) (City/State) (Zip Code)

Who Does the Child Live With? _____ Marital Status of Parents: _____

Name and Phone Number of Child's Pediatrician or Primary Care Doctor:

_____

Name and Phone Number of Doctor that Referred You Here Today:

_____

Mother ☐ ***Grandmother*** ☐ ***Stepmother*** ☐ ***Guardian*** ☐ ***Father*** ☐ ***Grandfather*** ☐ ***Stepfather*** ☐ ***Guardian*** ☐

Name:	Name:
Address:	Address:
Home Phone:	Home Phone:
Work Phone:	Work Phone:
Cell Phone / Pager:	Cell Phone / Pager:
SSN#:	SSN#:
Employer:	Employer:
Occupation:	Occupation:

PERSON RESPONSIBLE FOR PAYMENT
Name:_____ Relationship to Child: _____
Address: _____ Phone: _____

EMERGENCY NAME AND PHONE NUMBER (OTHER THAN PARENT / GUARDIAN)
Name: _____ Phone: _____

****PLEASE COMPLETE PAGE TWO – SIGN AND DATE ****

PRIMARY INSURANCE COVERAGE

Child's Name: _____ Insurance Company Name: _____

Child's Policy# or ID#: _____ Group#: _____

Insurance Company Address: _____

Insurance Company Phone Number: _____

Person Who Holds Insurance: _____ Relationship to Child: _____

Policy Holder's DOB: _____ Policy Holder's SSN#: _____

Policy Holder's Employer: _____

Does your child have a SECONDARY Insurance? YES ☐ NO ☐ **If YES**, Name of Insurance: _____

AUTHORIZATIONS & RELEASES

- I verify that the information I have given Pediatric Surgery, P.A. is valid and accurate.
- My dependent is covered by the above listed insurance(s) company(ies) and has no other medical insurance(s) coverage through my employer or otherwise.
- I authorize my insurance provider to pay all medical benefits to Mark S. Chaet, M.D. and/or Pediatric Surgery, P.A., directly, including those benefits otherwise payable to me.
- I authorize Pediatric Surgery, P.A. to release any information and medical records to my insurance provider, third party payors and/or other healthcare providers.

I have read the AUTHORIZATIONS & RELEASES. I understand and agree to the above state policy.

_____ _____

(Signature of Parent / Guardian) (Date)

FINANCIAL POLICY

- Pediatric Surgery, P.A. has agreed to bill my insurance provider for all services rendered with appropriate authorizations and referrals as required by my insurance provider.
- Authorization from my insurance provider does not always guarantee payment.
- My insurance provider may pay less than the actual bill for my services. I agree to be responsible for payment of all services rendered on my behalf or my dependent's behalf.
- Payment for all co-payments, deductibles and non-covered services is due at time of service.
- If I am not covered by a medical plan, I am responsible for payment in full at time of services.
- In the case of elective surgery, payments for all co-payments, deductibles and non-covered services are due in advance.
- Pediatric Surgery, P.A. is not a party to any divorce decree or other legal judgments that outlay responsibility for medical payments. The parent/guardian accompanying the child is responsible for payment.
- A charge of 1.5% interest per month may be added to my account if it becomes 90 days delinquent.
- Should collections become necessary, I will be responsible for all collection costs and reasonable attorney fees.

I have read the FINANCIAL POLICY. I understand and agree to the above stated policy.

_____ _____

(Signature of Parent / Guardian) (Date)