Pediatric Consultants of Troy

Child's Full Legal Name _____ Date of Birth _____

Address where child resides _____

City/State/Zip Code_____

Sex of child F / M Race _____ Ethnicity _____ Preferred Language _____

Mother's Name _____ Date of Birth _____

Address (if different than child) _____

City/State/Zip _____

Consent to Text **Y / N** Mobile _____ Home _____

Consent to Portal **Y / N** E-mail _____

Employer _____

Father's Name _____ Date of Birth _____

Address (if different than child) _____

City/State/Zip _____

Consent to Text **Y / N** Mobile_____ Home _____

Consent to Portal **Y / N** E-mail _____

Employer _____

Custody Restrictions

_____

_____

Primary Insurance Company _____

Policy Holder's Name _____ Date of Birth _____

Member ID # _____ Group # _____ Office Co-pay $_____

Relationship to Patient _____ Social Security # _____

Secondary Insurance Company _____

Policy Holder's Name _____ Date of Birth _____

Member ID # _____ Group # _____ Office Co-pay $_____

Relationship to Patient _____ Social Security # _____

Responsible billing party (please circle one) **Mother / Father**

Emergency Contact (other than parent)

Name _____ Phone # _____ Relationship _____

Please list all children that are current patients in our office & pertain to all information on PAGE 1

	Patient Name	Sex	Date of Birth
1.	_____	F / M	_____
2.	_____	F / M	_____
3.	_____	F / M	_____
4.	_____	F / M	_____
5.	_____	F / M	_____

Acknowledgement and Authorization - By signing below you agree to the following:

- **A $25.00 fee will be applied for any scheduled no show appointment that is not cancelled within 24 hours - after 3 no shows you will be dismissed from the practice**
- **A $50.00 fee will be applied for any scheduled Saturday no show appointment that is not cancelled within 24 hours**
- There is an additional **$35.00 fee** that will be billed to your insurance if you walk-in or have a scheduled appointment during the afterhours Night Owl Clinic
- All co-pays are due at time of service at check-in
- A $25.00 fee will be applied for all checks returned for insufficient funds
- Any past-due balance with no payment activity after 3 months will be sent to collections
- I have read and understand the HIPPA/Privacy Policy (posted by check-in window)
- I assign my insurance benefits to be paid directly to the healthcare provider
- I authorize to release medical information required to process my claim(s)
- I authorize to obtain/have access to my medication history
- We will see your child through college years as long he/she has their yearly Physical Exam

I have read and understand the Financial Policy**.** In addition, if in the event Pediatric Consultants of Troy does not receive any payment from the insurance company, it is understood that the responsible billing party will pay the full amount upon receipt of statement, whether by mail or in person.

Legal Signature _____ Date _____

(If insured is a minor, parent or guardian signature)