SOUTHINGTON PEDIATRIC ASSOCIATES
209 MAIN ST. SUITE A
SOUTHINGTON, CT 06489

PATIENT'S NAME_____ MALE/FEMALE_____ DOB_____
ADDT'L CHIDLREN_____ MALE/FEMALE_____ DOB_____
ADDT'L CHIDLREN_____ MALE/FEMALE_____ DOB_____
ADDT'L CHIDLREN_____ MALE/FEMALE_____ DOB_____
ADDRESS_____
CITY_____ STATE_____ ZIP CODE_____
HOME PHONE_____ CELL# OF PATIENT(IF 18 YRS OR OLDER)_____
**EMAIL(for Quest lab)_____

PARENT: FATHER

NAME_____ DOB:_____
ADDRESS(IF DIFFERENT FROM PT'S)_____
HOME #(IF DIFFERENT FROM PT'S)_____
PLACE OF EMPLOYMENT_____ WORK#_____
CELL#_____

MOTHER:
NAME_____ DOB:_____
ADDRESS(IF DIFFERENT FROM PT'S)_____
HOME# (IF DIFFERENT FROM PT'S)_____
PLACE OF EMPLOYMENT_____ WORK#_____
CELL#_____

MEDICAL INSURANCE

	PRIMARY	SECONDARY
NAME OF INSURANCE	_____	_____
SUBSCRIBER	_____	_____
MEMBER ID#	_____	_____
GROUP#	_____	_____
SS#(IF TRI CARE)	_____	_____

I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION TO RELEASE TO MY INSURANCE CARRIER OR ITS INTERMEDIARIES ANY INFORMATION NEEDED FOR ANY CLAIMS. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE ABOVE PHYSICIAN AND UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL SERVICES RENDERED WHICH MAY INCLUDE ANY CHARGES DUE FROM A WELLNESS VISIT. PLEASE BE ADVISED THAT OUR HIPAA POLICY IS AVAILABLE UPON REQUEST.

SIGNATURE_____ DATE_____

Please complete Back →

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OFFICE FINANCIAL POLICY

Thank you for being part of our pediatric family. We believe that good care for your children starts with good communication, and we have created this policy to help you understand the responsibilities that you may have for payments of our fees. If at any time you have questions or problems with our fees or payment process, we encourage you to contact our billing department and speak to our Practice Manager. Her phone number is 860-621-8331 opt. 2

On arrival, please check in at the front desk. Write the first name and last initial of your child and have a seat. Someone will be with you shortly. **Bring your insurance card to <u>every visit.</u> If the insurance card you present is incorrect, you will be financially responsible for any fees incurred during the visit.**

Please inform your insurance of the name of your Primary Care Physician. Due to multiple providers in our office, use our office name and NPI# 1659585149.

According to **your insurance plan you are responsible for any and all co-payments and/ or deductibles.** It is your responsibility to understand your benefit plan, to know if your plan requires a written referral to a specialist, and what services are covered. Remember that not all insurance plans cover a wellness visit every year and not all services rendered in our office are covered by your insurance plan.

If Southington Pediatric Associates does not participate with your insurance or you do not have insurance, you are responsible for payment at the time of service. For scheduled appontments, payment is expected prior to the visit. If you do not agree with your patient responsibility amount set by your insurance company, please contact your insurance to discuss the issue as this is a matter of your contract with them. Our billing department will be happy to discuss any issues you may have but you are still required to promptly pay the amount due to us even if you are in dispute with your insurance.

A $100 charge will be billed to you for NO SHOW APPOINTMENTS. A No Show Appointment is less than a 24 hour cancellation.

For forms not completed during a Wellness exam, a $5.00 per form will be charged for camp, sport, college, or FMLA forms and is expected before any forms will be given or faxed. We have a 3-5 day return time with filling out the form (s).

I have read and understand this office financial policy and I will be financially responsible for the following patient(s)
Patient(s) Name:

_____, _____, _____,
_____, _____, _____

_____ _____
Responsible Party's Name Relationship

_____ _____
Responsible Party's Signature Date