Southside Pediatric Center
Patient Information Update

PLEASE PRINT CLEARLY

PATIENT NAME:_____ GENDER: M / F DATE:_____

SSN:_____ DOB:_____ MARITAL STATUS:_____

ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____

HOME PHONE:_____ CELL PHONE:_____ WORK PHONE:_____

FINANCIAL RESPONSIBILITY

RESPONSIBLE PARTY NAME:_____ DOB:_____

SSN:_____ HOME #:_____ CELL #:_____ WORK #:_____

ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____

INSURANCE COVERAGE PLEASE PROVIDE COPIES OF ALL INSURANCE CARDS FOR OUR RECORDS

PRIMARY:_____ EFFECTIVE DATE:_____

INSURANCE PROVIDER:_____ DOB:_____

PRIMARY POLICYHOLDER:_____ SSN #:_____

RELATION TO PATIENT:_____ HOME #:_____ WORK #: _____

EMPLOYER:_____ OCCUPATION:_____ POLICY #_____

GROUP #:_____ INSURANCE CO PHONE #:_____

SECONDARY:_____ EFFECTIVE DATE:_____

INSURANCE PROVIDER:_____ DOB: _____

PRIMARY POLICYHOLDER: _____ SSN #:_____

RELATION TO PATIENT:_____ HOME #:_____ WORK #:_____

EMPLOYER:_____ OCCUPATION:_____ POLICY #:_____

GROUP #:_____ INSURANCE CO PHONE #;_____

THE UNDERSIGNED ACCEPTS FULL RESPONSIBILITY AND GUARANTEES PAYMENT IN FULL FOR ALL CHARGES INCURRED BY THE ABOVE NAMED PATIENT OF SOUTHSIDE PEDIATRIC CENTER. THE UNDERSIGNED FURTHUR UNDERSTANDS THAT SOUTHSIDE PEDIATRIC CENTER AS AN ACCOMODATION TO PATIENT, WILL FILE INSURANCE CLAIMS, IF ANY, ON PATIENTS BEHALF. THE UNDERSIGNED AGREES AND GUARANTEES PAYMENT FOR ALL CHARGES INCURRED BY PATIENT WHICH ARE NOT COVERED BY INSURANCE. IF PATIENTS INSURANCE COMPANY DENIES TREATMENT AS NOT MEDICAL NECESSARY OR IF PATIENT HAS NOT PROVIDED THE PROPER AUTHORIZATIONS FOR INTIAL OR CONTINUED TREATMENT, THE PATIENT ACKNOWLEDGES BY SIGNATURE BELOW THAT THE PATIENT OR FINANCIALLY RESPONSIBLE PARTY WILL BE RESPONSIBLE FOR PAYMENT OF SERVICES RENDERED.

SIGNATURE:_____ **DATE:** _____

Southside Pediatric CENTER

34-F Medical Park Boulevard
Petersburg, Virginia 23805
(804)-520-8135
Fax (804) 520-8092

WE WELCOME YOU . . .

We are board certified specialists in the provision of health care to infants, children, and adolescents. Everyone in this practice operates as a team member. As such, we act as advocates on your child's behalf. By providing ongoing primary care for your child through our group, you are ensuring the best care possible.

ABOUT FINANCIAL ARRANGEMENTS & MEDICAL INSURANCE

We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your understanding of our payment policy.

PAYMENT IS DUE AT THE TIME SERVICES ARE PROVIDED. We accept cash, checks, MasterCard or Visa. We will be happy to process claims with those insurance companies with which we participate, but you will be expected to pay any co-payments and/or percentages of lab fees at time of service. For all other insurance companies, you are responsible for all fees at time of service and must file for reimbursement from your insurance company.

We must emphasize that as medical care providers, our relationship is with you, not your insurance company. While the filing of claims with those companies with which we participate is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. If someone else is presumed liable for your bill, such as a divorced spouse, we will provide you with any necessary information to assist you with your claim. However, we look to the party receiving services for payment, and cannot be expected to wait for the conclusion of court cases or insurance disputes. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly prior to your office visit for assistance in the management of your account.

Should a check be returned to us for insufficient funds a $25.00 service charge will be applied to your account. Balances older than 30 days may be subject to additional collection fees. If it becomes necessary to refer your account to an agency or attorney for collection, you will be responsible for all fees that may be incurred, up to 1/3 (one-third) of your unpaid balance. If collection attempts by our billing office on your account prove to be unsuccessful then you will be dismissed from the practice and your account will be turned over to an outside source. Charges may also be made for broken appointments, especially those without 24 hours notice. A $25.00 no show fee will be applied to each child's account after the second occurrence.

We will gladly discuss your charges prior to office visits and any questions relating to your insurance. You must realize, however that:

1. Your insurance is a contract between you, your employer and the insurance company. We are not party to that contract.
2. Our fees are considered to fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the current standard and cost of care in this area referred to by insurance companies as UCR - usual, customary, and reasonable.
3. Not all services are a covered benefit in all contracts. It is your responsibility to know what services are covered by your policy. Should your insurance require services to be provided by another provider for various reasons it is your responsibility to make us aware which facility this is, i.e. lab procedures, x-ray and DME (durable medical equipment).

If you have any questions about the above information or any uncertainty regarding insurance coverage, PLEASE do not hesitate to ask us. We are here to help you.

By signing below I certify that I have read and understand the above information.

_____ _____

SIGNATURE **DATE**

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I, _____ give my permission for the following person's to bring my child/children to Southside Pediatric Center for treatment.

Name of Child/Children	Authorized Person/Relationship

I, _____ give Southside Pediatric Center permission to disclose health information on my child/children to the following persons.

Name of Child/Children	Authorized Person/Relationship

_____ _____
Print Guardian Name **Date**

_____ _____
Sign Guardian Name **Date**

_____ _____
Witness Signature **Date**

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Consent for Treatment

As parent or legal guardian (circle one) for _____ ,

I give permission for Southside Pediatric Center to authorize any and all medical treatment my child may need.

This consent is valid from _____ to _____.

Signature of parent or guardian _____ Date _____