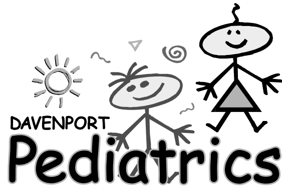


PATIENT INFORMATION

Patient's Name ______________________ Male / Female **Birth Date** __________
(Last, First, MI)
Social Security # ______________________ Home Phone # ______________________
Cell Phone # ______________________ Other Phone # ______________________
Home Address ______________________

Mailing Address ______________________

PERSON RESPONSIBLE FOR ACCOUNT (Parent / Legal Guardian)
Mother's Name ______________________ SS # __________
Driver's License # ______________________ Birth Date __________
Address ______________________

Employer ______________________
Work # ______________________

Father's Name ______________________ SS # __________
Driver's License # ______________________ Birth Date __________
Address ______________________

Employer ______________________
Work # ______________________

Legal Guardian ______________________ SS # __________
Driver's License # ______________________
Birth Date ______________________ Relationship __________
Address ______________________

Employer ______________________
Work # ______________________

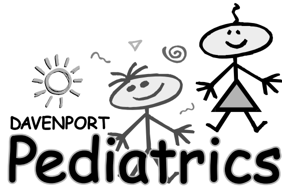
EMERGENCY CONTACT
(Please list a relative or friend (not of the same address) for us to contact in case of an emergency)
Name ______________________ Relationship __________
Address ______________________

Daytime Phone ______________________ Alternate Phone __________

I certify that the information I have provided is correct and current. I authorize DAVENPORT PEDIATRICS, PA, its physicians and support staff to provide medical care to the patient named above.

SIGNATURE ______________________ **DATE** __________
Parent / Legal Guardian of Patient

PRINTED NAME (Parent / Legal Guardian) ______________________



PATIENT NAME ______________________________ **Birth Date** ______________

INSURANCE INFORMATION

PRIMARY INSURANCE ______________________________ Phone # ______________
Address of Insurance Co. ______________________________
Policy ID # ______________________ Group # ______________________
Name of Policy Holder ______________________ Relationship ______________
Policy Holder's SS # ______________________ Policy Holder's Birth Date ______________

SECONDARY INSURANCE ______________________________ Phone # ______________
Address of Insurance Co. ______________________________
Policy ID # ______________________ Group # ______________________
Name of Policy Holder ______________________ Relationship ______________
Policy Holder's SS # ______________________ Policy Holder's Birth Date ______________

For the Siblings of Patient on the Same Insurance Policy, please list the Sibling's Names & Birth Dates:

____
____
____

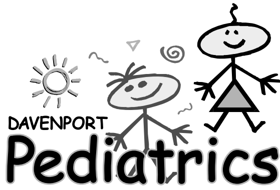
I, ______________________________ **, understand that if for any of the following**
(Parent or Legal Guardian)
reasons, payment is not made by the insurance company within the period of ninety (90) days from the date services are rendered for ______________________________ **, the undersigned will**
(Patient's Name)
be responsible for payment in full of any unpaid charges on this account.

(1) We are an Out-of-Network Provider. We do not participate with your insurance company.
(2) Claim is rejected. There is No Coverage at the time of service.
(3) We are not the assigned primary care physician for the patient or for the insurance.
(4) Procedure / Lab work is not a covered service.
(5) Procedure / Lab / Physicals, etc. are not covered benefits.
(6) Insurance company is awaiting requested information from parent / legal guardian of patient.
(7) Your insurance company has made payment and the remaining balance is your responsibility.
(8) Only hospital charges are covered.

There may be many other reasons as to why your insurance company may reject a claim filed on your behalf. If there are any questions regarding their decision/s, you must contact your insurance company immediately.

I have carefully read and understand the above stated Patient Responsibilities, and agree to abide by its terms. I also understand and agree that such terms may be amended by DAVENPORT PEDIATRICS, PA from time to time.

SIGNATURE ______________________________ **DATE** ______________
(Parent / Legal Guardian / Guarantor of Account)



PATIENT NAME ______________________________ **Birth Date** ______________

AUTHORIZATION TO RELEASE MEDICAL INFORMATION
I authorize the release of any medical information necessary to process an insurance claim for services rendered by DAVENPORT PEDIATRICS, P.A. I certify the information provided is correct. I authorize and assign payment of medical benefits to DAVENPORT PEDIATRICS, P.A. for services rendered. This assignment will remain in effect until revoked by me in writing. A photocopy of this form is to be considered as valid and effective as the original.

________**INITIALS**

ASSIGNMENT OF HEALTH INSURANCE BENEFITS
I authorize payment of medical benefits applicable to services cited on the claim form to DAVENPORT PEDIATRICS, P.A.

________**INITIALS**

CONSENT FOR TREATMENT
This consent is valid during the entire term of my association with DAVENPORT PEDIATRICS, P.A. and may be relied upon by DAVENPORT PEDIATRICS, P.A. unless, and until revoked by the patient or those legally responsible for the patient, in writing. Knowing that the patient is suffering from a condition requiring medical treatment, I do hereby voluntarily consent to such diagnostic procedures as are necessary in the judgment of the physician(s) in charge. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the results of the examination or treatment in the hospital or office.

________**INITIALS**

GUARANTEE OF ACCOUNT
I/We hereby authorize DAVENPORT PEDIATRICS, P.A. to provide such information as may be required by state or federal agencies or my insurance company, and for and in consideration of the services rendered to the patient, I/we , the undersigned, jointly or severally, promise to pay to DAVENPORT PEDIATRICS, PA. the full amount of charges for such services, on demand, or by such future date as may be determined by DAVENPORT PEDIATRICS, P.A. I/We understand that the bill will be due and payable in full on or before such date. I acknowledge that interest or a fee, at the provider's current rate, may be charged on all balances owing to the provider that are past due. In the event of default, I agree to pay a reasonable attorney's fees and costs.
Cancelled or missed appointments, within 24 hours will be subject to a $25.00 service fee.

________**INITIALS**

ACKNOWLEDGEMENT FOR RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have been presented with a copy of Davenport Pediatrics, P.A.'s Notice of Privacy Practices. I am aware that I may have a copy of the Notice of Privacy Practices to keep in my possession.

SIGNATURE ______________________________ **DATE** ____________________
Parent / Legal Guardian of Patient

PRINTED NAME (Parent/Legal Guardian) ______________________________