Patient Information

Amy L. Voelker, M.D., FAAP
Allison S. Hettinger, M.D., FAAP
Shawna C. Patch, M.D., FAAP
Connor Hosty, M.D., FAAP

Patient Information:

Child's Legal Name: _____ Sex: M F

Child's Nickname: _____ Birth Date: _____

Address: _____ Apt # _____

City: _____ State: _____ Zip: _____ Phone: _____

Email Address: _____ Race: _____

Ethnicity: Hispanic or Latino Not Hispanic or Latino

Family Information:

Child is living with: Both Parents One Parent Alone Parent & Step Parent Other: _____

Who is responsible for account? _____

Father's Name: _____ Cell Phone: _____

Employer: _____ Work Phone: _____

Mother's Name: _____ Cell Phone: _____

Employer: _____ Work Phone: _____

Emergency Contact: _____

Name Relationship Phone #

Please list other children in the household:

Name	Birth Date
_____	_____
_____	_____
_____	_____

Consent is hereby given to perform any and all examinations, tests, procedures, and treatments necessary and/or advisable; and in an emergency, without the presence of parents or responsible adults. I have read Preferred Pediatrics office and financial policies available on their website www.preferredped.com.

Signed: X_____ **Date**: _____

Patient Information

Preferred Pediatrics

Amy L. Voelker, M.D., FAAP
Allison S. Hettinger, M.D., FAAP
Shawna C. Patch, M.D., FAAP
Connor Hosty, M.D., FAAP

CHILD'S NAME: _____

INSURANCE INFORMATION:

Primary Insurance Company _____ Copay_____

Policy Holder's Name _____ Birth Date _____

Social Security # _____ INSURANCE ID#_____ Group #_____

Employer Name _____ Employer Phone # _____

Insurance Company Address: _____

(Street or P.O. Box #) City, State, ZIP

Insurance Phone #_____

Secondary Insurance Company _____ Copay_____

Policy Holder's Name _____ Birth Date _____

Social Security # _____ INSURANCE ID#_____ Group #_____

Employer Name _____ Employer Phone # _____

Insurance Company Address: _____

(Street or P.O. Box #) City, State, ZIP

Insurance Phone #_____

INFORMATION CONCERNING FILING A CLAIM WITH YOUR INSURANCE COMPANY

If we participate with your primary insurance, Preferred Pediatrics will gladly file a claim for you. We will allow your insurance company up to 45 days from the date of service to pay the claim. If your company fails to fully compensate Preferred Pediatrics, any unpaid balance becomes the sole responsibility of the insured and is due upon notification from our office. Any co-payments or payment for non-covered services are due at the time of service. Preferred Pediatrics **cannot bill for co-payments**. Guarantor will be responsible for collection agency fee if account is turned over for collection.

AUTHORIZATION TO FILE INSURANCE CLAIMS, TO RELEASE MEDICAL INFORMATON, AND ASSIGNMENT OF BENEFITS

I hereby AUTHORIZE Preferred Pediatrics to file insurance claims for services and supplies rendered to and for my child(ren). I also AUTHORIZE Preferred Pediatrics to release information, including my child(ren)'s medical and billing information, to my referring doctor, insurance company, or the responsible party named above. I hereby ASSIGN to Preferred Pediatrics all payments for medical services rendered to my dependent child(ren).

ACKNOWLEDGEMENT

I ACKNOWLEDGE that the above information is correct, that I am responsible for the balance on my account for any services not covered by my plan.

Signed: X_____ **Date:** _____