PC PEDIATRIC CARE OF ROCKVILLE, P.A.

PATIENT INFORMATION

PATIENT NAME _____ DATE OF BIRTH_____ SEX____

ALLERGIES TO MEDICATIONS_____

ADDRESS _____HOME PHONE (_____)_____LANGUAGES_____

CITY/STATE/ZIP _____RACE_____ETHNICITY_____

PARENT/GAURDIAN INFORMATION

PARENT/GAURDIAN NAME _____ RELATIONSHIP TO PATIENT _____

CELL PHONE (____)_____HOME PHONE (____)_____WORK PHONE (____)_____

ADDRESS_____CITY/STATE/ZIP_____

OCCUPATION_____EMPLOYER_____EMAIL_____

PARENT/GAURDIAN NAME _____ RELATIONSHIP TO PATIENT _____

CELL PHONE (____)_____HOME PHONE (____)_____WORK PHONE (____)_____

ADDRESS_____CITY/STATE/ZIP_____

OCCUPATION_____EMPLOYER_____EMAIL_____

PRIMARY INSURANCE

COMPANY_____

POLICY NUMBER_____

GROUP NUMBER_____

POLICY HOLDER_____

POLICY HOLDER'S DOB_____

RELATIONSHIP TO PATIENT_____

WHO IS RESPONSIBLE FOR COPAYS? _____

SECONDARY INSURANCE (IF APPLICABLE)

COMPANY_____

POLICY NUMBER_____

GROUP NUMBER_____

POLICY HOLDER_____

POLICY HOLDER'S DOB_____

RELATIONSHIP TO PATIENT_____

WHO SHOULD RECEIVE ANY BILLS?_____

BROTHERS AND SISTERS	DATE OF BIRTH	SEX	ALLERGIES TO MEDICATIONS
1.			
2.			
3.			
4.			

The Guarantor accepts financial responsibility for all services rendered to the patients(s) above by Pediatric Care of Rockville, P.A. (hereinafter "PCR"). The Guarantor authorizes PCR to release any medical information necessary to process any insurance claim to any insurance company, and the Guarantor assigns any monies due and owing under the insurance contract to PCR. In the event that the patient's insurance plan does not cover the services rendered (or any portion thereof), the Guarantor accepts financial responsibility for any remaining balance. In the event that the account is turned over to an agency for collection, the Guarantor hereby agrees to pay all costs of collection including but not limited to, agency fees, court expenses and attorney fees. A minimum of 24 hours' notice is required for cancellation of all appointments. If this notice is not received, the Guarantor will be charged a missed appointment fee. Insurance companies will not be billed for missed or canceled appointments. All co-payments are expected at the time of service. The office accepts cash, checks, Visa and MasterCard. Patients covered by insurance plans in which PCR does not participate are considered "self-pay" and are required to make payment in full at the time of service. The Guarantor understands the additional charges including, but not limited to, fees for copying records, returned checks, health forms, letters or telephone consultations, may be charged to their account and will not be billable to their insurance. The Guarantor accepts financial responsibility for these charges, if applicable. The Guarantor is responsible for providing PCR with a current copy of the patient's insurance card, and, if applicable selecting one of the PCR's providers as the patient's primary care physician. PCR does not guarantee that each service will be covered or what percentage will be covered. The Guarantor hereby agrees to be bound by these terms and conditions. A copy of the authorization may be used in place of the original.

NAME _____ DATE _____

SIGNATURE _____ RELATIONSHIP TO PATIENT _____