Insurance Information

Child's Name: First ______________________ Last ____________________________ **Date of Birth** ____________

Primary Insurance

Cardholder's Full Name: First ____________________________________ Last _______________________________________

Social Security _________________________ Date of Birth ____________________ Relationship to child _________________________

Address (if different than child's) ____

City ______________________________________ State _________ Zip _____________________

Phone ( ) _________________________________ Work ( ) _______________________________

Employer ____ Business Phone ( ) _____________________________

Employer Address____City/State________________________Zip______________

Insurance Company _____________________________________ID # ____________________________ Group# __________________

Effective Date of insurance ____________________

*****WE NO LONGER ACCEPT SECONDARY INSURANCE, EXCEPT IN CASES OF DISABILITY*****

Secondary Insurance

Cardholder's Full Name: First _______________________________ Last ____

Social Security _________________________ Date of Birth ____________________ Relationship to child _________________________

Address (if different than child's) ____

City ______________________________________ State _________ Zip _____________________

Phone ( ) _________________________________ Work ( ) _______________________________

Employer ____ Business Phone ( ) _____________________________

Employer Address____City/State________________________Zip______________

Insurance Company _____________________________________ID # ____________________________ Group# __________________

Effective Date of insurance ____________________

PAYMENTS AND INSURANCE AUTHORIZATION / ASSIGNMENT OF BENEFITS

It is the policy of this office that all payments for medical services be made *at the time of your visit, or before in some cases*. This payment is required regardless of who brings the child in to be seen. In the case of separated or divorced parents, responsibility and payment shall belong to the guardian bringing the child in for treatment. For example, if parent #1 is financially responsible for medical expenses, and parent #2 is bringing that child in for treatment, payment will still be expected from parent #2 at the time of service.

Initial______ I understand and agree that regardless of what benefits are quoted, or misquoted, by my insurance company when you check my insurance status, I am ultimately responsible for any deductible, co-insurance/copays, or any other balance not paid by my insurance company. This includes services provided that the insurance company deems not medically necessary.

Initial______ I understand that I must pay my copay or co-insurance at the time of service, regardless of who accompanies my child to his/her visit. Without my copay or co-insurance, I may be charged a late-fee.

Initial______ I understand that I must pay my deductible responsibility, if I have one, at the time of service. If I cannot pay the entire deductible balance, a $50 deductible deposit will be required at each visit until my deductible has been met. If I request to be billed for a deductible balance, I must pay within 30 days, or I will lose the privilege of being billed. I will then be required to pay in full at each visit.

Initial______ I must have proof of insurance at every visit or I will have to pay in full to be seen. If I have a newborn, I will have to present proof of application by the 30 day mark if I do not have my baby's proof of insurance by then.

Initial______ I understand that I am responsible for any costs incurred in the collection of my child's account in case of default, including reasonable attorney fees, court fees and agency fees.

Initial______ I understand that bad checks are sent to the York County Solicitor's Worthless Check Unit, for which there will be a $30 charge from our office. Failure to pay the check and all fees could result in arrest and criminal prosecution.

Initial______ I understand that well and sick benefits may be handled differently by my insurance company, and if during a well visit, my child is sick, or has an issue needing treatment and/or medical attention, my provider may bill for both services. Regardless of what the well visit benefits are, I will be responsible for any charges my insurance passes on to me for the sick visit portion.

I hereby grant permission to Sunshine Pediatrics, LLC to release any pertinent information to my insurance company upon request, and I also authorize transfer of benefits to Sunshine Pediatrics, LLC. A photocopy of this authorization shall be considered as valid as the original.

Signature: _________________________________Print Name ____________________________________ Date: __________________