PATIENT INSURANCE FORM

Patient Name: _____ Sex: M F Date of Birth: _____
First Name Middle Initial Last Name

Chronic Conditions: _____ _____ **Last WCC:** _____ **vaccinations:** Y N

PARENT (check one) Biological Step Foster Other:_____

Name: _____ DOB: _____ SEX: M F SS#: _____-_____-_____
First Middle Initial Last

PARENT (check one) Biological Step Foster Other:_____

Name: _____ DOB: _____ SEX: M F SS#: _____-_____-_____
First Middle Initial Last

Primary Insurance: _____ Address: _____
Identification # _____ Group #: _____
Subscriber: _____ DOB: _____ SS#: _____- _____ - _____
Address: _____ Phone Number: _____
Employer: _____ Relationship to child: mother father other: _____

Secondary Insurance: _____ Address: _____
Identification # _____ Group #: _____
Subscriber: _____ DOB: _____ SS#: _____- _____ - _____
Address: _____ Phone Number: _____

Employer: _____ Relationship to child: mother father other: _____

Initials: _____ **It is your responsibility to contact/update coordination of benefits with BOTH insurances in order for claims to be processed, claims that are denied due to COB issues are patient responsibility.**

Initials: _____ **I have reviewed the posted Notice of Privacy Practices for Surprise Pediatrics as part of the Health Insurance Portability and Accountability Act (HIPAA).**

Initials: _____ **I have received a copy of the Surprise Pediatrics Financial and Office Policies (Sept 2017). I agree to abide by all of its terms and conditions knowing that failure to comply may result in discharge from the practice.**

Initials: _____ **I am responsible for knowing my insurance benefits and updating all information with my insurance(s) as needed.**

I am aware that a Well / Sick combined Medical Diagnosis may occur resulting in treatment and additional charges such as Labs, Prescriptions or additional testing. These additional charges may or may not be covered by my Insurance or may be applied to my Deductable, Co-Insurance or out of pocket copay.

I hereby confirm that the above information is complete and accurate, and that I am the responsible party for this minor. I hereby authorize Surprise Pediatrics to examine and treat my child when necessary. I also authorize the release of protected health information, acquired in the course of examination, to carry out treatment, payment, and the healthcare operations of my child. I authorize my insurance benefits to be paid directly to Surprise Pediatrics. I understand that I am responsible for any unpaid balance for services rendered but not covered by my insurance policy (ies). If my account is referred for collection, I agree to pay the balance due, collection fee of 40%, all attorneys' fees, and any other associated costs incurred.

Parent/Legal Guardian Printed Name: _____ **Relationship to child:** _____
Parent/Legal Guardian Signature: _____ **Date:** _____

14239 W BELL RD, #112, SURPRISE, AZ 85374
623-876-9983 FAX: 623-876-9984

FAMILY FINANCIAL RESPONSIBILITY FORM

RESPONSIBLE PARTY: (check one) Biological Step Foster Other:_____

Name: _____ DOB: _____ SEX: M F SS#: _____-_____-_____
First Middle Initial Last

Address: _____ City/State/Zip:_____

Home Phone :(_____) _____ - _____ Cell Phone :(_____) _____ - _____

Employer: _____ Work Phone:(_____) _____ - _____

Email:_____ SPOUSE: _____ DOB:_____

OTHER GUARDIAN: (check one) Biological Step Foster Other:_____

Name:_____ DOB:_____ SEX: M F SS#: _____-_____-_____
First Middle Initial Last

Address: _____ City/State/Zip:_____

Home Phone :(_____) _____ - _____ Cell Phone :(_____) _____ - _____

Employer: _____ Work Phone :(_____) _____ - _____

Email:_____ SPOUSE: _____ DOB:_____

PATIENT:_____DOB:_____ PATIENT:_____DOB:_____

PATIENT:_____DOB:_____ PATIENT:_____DOB:_____

PATIENT:_____DOB:_____ PATIENT:_____DOB:_____

PATIENT:_____DOB:_____ PATIENT:_____DOB:_____

The following people have my permission to authorize medical treatment if we, the parents/legal guardians, are not available to give consent. I understand that it is our responsibility to notify Surprise Pediatrics in writing of any changes to this list.

Name _____ Name _____
DOB: _____ Phone _____ DOB: _____ Phone _____
Relationship to child _____ Relationship to child _____

Initials: _____ **I have reviewed the posted Notice of Privacy Practices for Surprise Pediatrics as part of the Health Insurance Portability and Accountability Act (HIPAA).**

Initials: _____ **I have received a copy of the Surprise Pediatrics Financial and Office Policies (Sept 2017). I agree to abide by all of its terms and conditions knowing that failure to comply may result in discharge from the practice.**

Initials: _____ **I am responsible for knowing my insurance benefits and updating all information with my insurance(s) as needed.**

I am aware that a Well / Sick combined Medical Diagnosis may occur resulting in treatment and additional charges such as Labs, Prescriptions or additional testing. These additional charges may or may not be covered by my Insurance or may be applied to my Deductable, Co-Insurance or out of pocket co-pay.

I hereby confirm that the above information is complete and accurate, and that I am the responsible party for this minor. I hereby authorize Surprise Pediatrics to examine and treat my child when necessary. I also authorize the release of protected health information, acquired in the course of examination, to carry out treatment, payment, and the healthcare operations of my child. I authorize my insurance benefits to be paid directly to Surprise Pediatrics. I understand that I am responsible for any unpaid balance for services rendered but not covered by my insurance policy (ies). If my account is referred for collection, I agree to pay the balance due, collection fee of 40%, all attorneys' fees, and any other associated costs incurred.

Parent/Legal Guardian Printed Name:_____

Parent/Legal Guardian Signature:_____ **Date:**_____

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