Van Dorn Pediatrics, P.C.

PATIENT REGISTRATION

Patient's Name: _____ **Date of Birth**: _____ **Gender: M F**
(First) (Last)

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(First) (Last)

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(First) (Last

Home Address:_____ **Apt:**_____
City: **State:** **Zip Code:**

If newborn, hospital name of Birth:

Primary Phone: ( ) **Who May We Thank For Your Referral:**

Mother's Name:_____ Date of Birth _____
Social Security Number: _____ Occupation: _____
Cell Phone: **( )** Work Phone: **( )**

Father's Name:_____ Date of Birth: _____
Social Security Number: Occupation:_____
Cell Phone: **( )** Work Phone: **( )**

Pharmacy Name: **Pharmacy Number: ( )**

Legal Guardian: _____ **DOB**: _____ Primary Phone: **( )**

Emergency contact (other than parents, not living in the same household**)**
Name**:** Phone**: ( )**

Patient Portal

When you sign up for the patient portal, you may view the following:

- Scheduled appointments
- Cancel Appointments
- Receive Appointment Reminders & Confirmations
- Submit non-urgent questions or messages
- View and update your child's information

Please provide us with your email so that you may receive a link to the portal with your log in and password.
Email:_____

INSURANCE & BILLING INFORMATION

Payments are required at time of service (unless prior arrangements have been made)

Name of Responsible Party: **Phone**#: ( )

Billing Address (if different from above):

Subscriber's Name:_____ **Effective Date:** _____
Primary Insurance name: _____ **ID**#:_____**Group**#:_____

Secondary Insurance name: **ID#:** **Group#:**

I hereby authorize direct payment of surgical / medical benefits to **Van Dorn Pediatrics, P.C.** for services rendered by the staff. I understand that I am financially responsible for any balance not covered by my insurance. I certify that the information given by me in applying for payment is correct.

PARENT / GUARDIAN (please print**)**_____

Signature _____ **DATE**_____

Van Dorn Pediatrics
Payment Policy

1. Insurance: We participate in most insurance plans, including Medicaid. If you are not insured by a plan with which we do business, payment in full is expected at each visit. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Proof of insurance. All patients are required to provide proof of insurance on the day of their visit. Some insurances also request that we have a SSN (Social Security Number) in order for claims to get submitted. Please always keep this in mind and be willing to provide it, if ever asked. If you have a secondary insurance please present it to the front desk so we can have a record of it.

3. Coverage changes. If your insurance changes, please notify us as soon as possible so that changes can be made immediately, ensuring that claims are submitted to the correct insurance. Failure to notify us may lead to delay in claim submission, and you may be responsible for the visit.

4. **Guarantee of payment.** Our practice recommends that you place **a credit card on file** for co-payments, deductibles, and to resolve any remaining balances after treatment. If your insurance has a contract with Van Dorn Pediatrics, you are not responsible for amounts that are agreed to be written off. If your insurance does not have a contract with Van Dorn Pediatrics, you are responsible for any amounts not paid by your insurance plan. Your credit card on file will be used for these types of payments. In the event that you default on payment of your account, you are responsible for any and all costs incurred on the collection of your account, including court costs and reasonable attorney's fee. If the debt is assigned to a third party collection agency, you are responsible for collection fees and interest due to amounts in default.

6. **Missed appointments**. You will be charged for every missed appointment if not cancelled within 24 hours of scheduling, including appointments made within the same day. Missed well child visits are subject to a fifty dollar ($50) fee, and missed sick or follow up visits are subject to a twenty dollar ($20) fee for no show or late cancellation.

7. Forms: There will be a $10 processing fee for all forms (sports, school, physicals and medical).

8. **Collections:** Three statements will be sent before patient is sent to collections. An additional fee will be added once in collections.

I have read and understand the payment policy and agree to abide by its guidelines:

Signature of patient/responsible party: **_____**

Date: _____