

Eastern Shore Children's Clinic - Patient Information

Child's Name _____ Today's Date _____
Child's Nickname _____ Child's Sex (circle): Male or Female
Child's Birth Date _____ Social Security Number _____
Race (circle): American Indian/Alaskan | Asian | Black/African American | White | Other _____
Ethnicity (circle): Hispanic/Latino or Non-Hispanic/Non-Latino
Language (circle): English Spanish French Other _____
Parent's Marital Status (circle): Married Divorced Single Widowed
Mother's Name _____ Mother's Social Security # _____
Mother's Home Phone _____ Mother's Cell Phone _____
Mother's Mailing Address _____ City _____ State _____ Zip _____
Mother's Employer _____ Mother's Work Phone _____
Mother's Drivers License Number _____ Mother's Date of Birth _____
Father's Name _____ Father's Social Security # _____
Father's Home Phone _____ Father's Cell Phone _____
Father's Mailing Address _____ City _____ State _____ Zip _____
Father's Employer _____ Father's Work Phone _____
Father's Drivers License Number _____ Father's Date of Birth _____
Child Lives With (circle one): Both Parents Mother Father Other _____
Parent's Home Email Address _____
Emergency Contact _____ Relationship _____ Phone # _____

Insurance Information

Please provide Insurance card(s) and Driver's License so we can copy for our records

Insurance Company _____ Subscriber's Name _____
Subscriber's Policy Number _____ Group # _____
Co-pay Amount _____ Subscriber DOB _____ Secondary Insurance? Yes or No

Pharmacy Information

Preferred Pharmacy _____ Pharmacy phone number _____

Family Information

Sisters (Full Name) _____	Date of Birth _____	Brothers (Full Name) _____	Date of Birth _____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Financial Responsibility

I understand that it is my responsibility to provide current and correct insurance information on the date of service. I agree to accept financial responsibility for any procedure that is either not covered by my insurance company or not paid by my insurance company within a timely manner. Appointments not cancelled at least 4 hours prior to your appointment time will be considered "no-shows". We reserve the right to bill you \$25.00 for each no-show. This fee will be your responsibility and will not be billed to your insurance company.

Signed _____ Date _____

Relationship to the Child _____

What was the reason you chose our practice? _____

EASTERN SHORE CHILDREN'S CLINIC FINANCIAL POLICY

We here at Eastern Shore Children's Clinic (ESCC) are doing everything possible to hold down the cost of medical care. You can help a great deal by eliminating the need for us to bill you. The following is a summary of our financial policy.

ALL PAYMENT IS EXPECTED AT THE TIME OF SERVICE

Payment is expected at the time services are rendered unless other arrangements have been made in advance. I understand that I am responsible for any unpaid balance, copayments, coinsurance, deductibles and non-covered charges and unconditionally guarantee payment in full to ESCC for all treatment and services rendered to the patient. Failure to pay copayments on the service date may result in an additional fee. ESCC accepts cash, checks, debit cards, VISA, MasterCard, American Express, and Discover. There is a service charge for returned checks and we reserve the right to make your account a "cash only" account for future visits.

Patients with an outstanding balance are asked to pay their balance in full at time of receipt of their statement. We do realize that patients may have financial difficulty. Therefore, we advise you to call our Billing Coordinator, at 928-0624, extension 233, Tuesday through Friday between 9:00 a.m. and 4:00 p.m. to discuss your account.

INSURANCE

We bill participating insurance companies as a courtesy to you (*this includes Commercial Insurance, Group Insurance, and Medicaid*). You are expected to be familiar with what your copayment amounts are, what your yearly deductible is, what your insurance does or does not cover, etc. There are too many plans within plans for us to be able to know them all. Your employer provides numbers for you to call to ask these questions. When we check for eligibility at the time of your appointment and your insurance shows ineligible, you are responsible for the entire bill at the time of service.

MISSED APPOINTMENTS / LATE CANCELLATIONS

Cancellations should be made no later than 4 hours prior to your scheduled appointment time. Appointments not cancelled at least 4 hours prior will be considered "no-shows". Arriving more than 15 minutes late for an appointment will also be considered a no-show. No-show appointments represent a cost to us, to you, and to other patients that could have been seen at the time set aside for you. We reserve the right to bill you \$25.00 for each no-show. This fee will be your responsibility and will not be billed to your insurance company. After three (3) no-shows we reserve the right to dismiss your family from our practice.

I have read and understand the ESCC Financial Policy. I agree to assign insurance benefits to ESCC whenever necessary. I also agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I also will be responsible for the 33% fee charged by the collection agency on the total balance owed.

Signature of Insured or Authorized Representative: _____

Printed Name of Insured or Authorized Representative: _____

Date: _____