Eastern Shore Children's Clinic - Patient Information

Child's Last Name _____Child's First Name _____Child's Middle Initial___
Child's Date of Birth_____Child's Sex (circle): M| F Child's SSN_____
Address/City/State/Zip_____
Primary Phone_____Day Phone_____Cell Phone_____
Email address_____ Will you accept e-mail notifications (circle): Yes|No
Emergency Contact _____Relationship _____Phone _____
Language (circle): English | Spanish | French | Other_____
Ethnicity (circle): Hispanic/Latino or Non-Hispanic/Non-Latino
Race (circle): American Indian/Alaskan | Asian | Black/African American | White | Other _____
Parent's Marital Status (circle): Married | Divorced | Single | Widowed
Child Lives With (circle one): Both Parents | Mother | Father | Other _____

Mother's Information

Last Name _____First Name_____Middle Initial_____
Social Security #_____Birth Date_____ Drivers License #_____
Address/City/State/Zip_____
Email _____Will you accept e-mail notifications (circle): Yes|No
Employer_____Occupation_____
Primary Phone _____Work Phone_____
Cell Phone _____Reminder Calls (Circle): Home|Work|Cell|Text Cell

Father's Information

Last Name _____First Name_____Middle Initial_____
Social Security #_____Birth Date_____ Drivers License #_____
Address/City/State/Zip_____
Email _____Will you accept e-mail notifications (circle): Yes|No
Employer_____Occupation_____
Primary Phone _____Work Phone_____
Cell Phone _____Reminder Calls (Circle): Home|Work|Cell|Text Cell

Insurance Information

Subscriber's Last Name_____First Name_____Middle Initial____
Sex (circle): Male | Female Date of Birth_____Relationship to Subscriber_____
Insurance Company _____Policy Number _____Group #_____
Co-pay Amount_____ Secondary Insurance? Yes | No

Pharmacy Information

Preferred Pharmacy_____ Pharmacy phone number _____

Family Information

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

Signed _____ Date_____ Relationship to the Child _____
What was the reason you chose our practice?_____

(Revised 06/04/2018)

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: _____