

Eastern Shore Children's Clinic
Updated Patient Information

Child's Last Name _____ Child's First Name _____ Child's Middle Initial ____
Child's Preferred Name _____
Child's Birth Date _____ Child's SS# _____
Address/City/State/Zip _____
Primary Phone _____ Daytime Phone _____ Cell Phone _____
Parent's marital Status (circle) Married | Divorced | Single | Widowed
Child lives with (circle one) Both parents | Mother | Father | Other _____
Parent | Guardian Name _____ Contact # _____
Parent | Guardian Name _____ Contact # _____

Pharmacy Information

Preferred Pharmacy | City | State | Phone Number _____

Insurance Information

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

Subscriber's Last Name _____ First Name _____ Middle Initial ____
Gender (circle) Male | Female Date of Birth _____ Relationship to Subscriber _____
Insurance Company _____ Policy Number _____ Group# _____
Co-pay Amount _____ Secondary Insurance? Y or N

Family Information

<u>Sisters (Full Name)</u> _____	<u>DOB</u> _____	<u>Brothers (Full Name)</u> _____	<u>DOB</u> _____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Signed _____ Date _____ Relationship to Child _____

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 Patient Account Representative, 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 1 hour prior to your scheduled appointment time. Appointments not cancelled at least 1 hour 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 for each no-show. 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: _____