WESTSIDE PEDIATRICS

LACTATION/EDINBURGH INFORMATION SHEET

Mother's Demographics

Mother's Name: _____ DOB: _____ SSN: _____
Address (if different from child) _____ City: _____ State: ____
Home Phone: _____ Cell Phone: _____ Email:_____
Employer: _____ Work Phone: _____

INSURANCE INFORMATION

Primary Policy Holder: _____ D.O.B: ___/___/___ Relationship: _____
Social Security Number: _____ Insurance Co. Name: _____
Insurance Co. Address: _____ Phone Number: _____
Policy Number: _____ Group Number: _____
Co-pay Amount $_____ Policy Effective Date___/___/___

We do not bill secondary insurance companies or insurance companies that we do not participate with. Note: The health plan of the parent whose birthday comes first in the calendar year is designated as the primary plan.

Please be advised that there is a **24 hour cancellation policy**. I understand that failure to adhere to this policy may result in a $75 missed appointment fee for well visits and $50 for all others. **Initial** _____

Assignments of Benefits
I, the undersigned, request that payment of all insurance benefits payable for medical services provided, be made directly to the physicians of Westside Pediatrics P.C. In addition, I authorize the release of any medical information, as permitted by the law necessary to process a health insurance claim form.

Beneficiary Agreement
I do hereby acknowledge that I was informed that in the event that my health care insurance plan denies payment for services received at Westside Pediatric P.C. I agree to be personally responsible for the payment of these services. It is therefore my responsibility to contact my insurance carrier to confirm the coverage provisions.

HIPPA
A copy of Westside Pediatrics' Notice of Privacy Practices as Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) is available at the front desk. I understand that this is a HIPAA compliant office.

Sign _____ Print Name _____ Date _____

WESTSIDE PEDIATRICS

FINANCIAL POLICY

We 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 payment policy.

ALL PAYMENT IS EXPECTED AT THE TIME OF SERVICE

Payment is required at the time services are rendered unless other arrangements have been made in advance. This includes applicable coinsurance and co-payments for participating insurance companies. Westside Pediatrics P.C. accepts cash, personal check (in-state only), American Express, VISA and MasterCard. There is a service charge for returned checks.
Patients with an outstanding balance of 60 days overdue must make arrangements for payment prior to scheduling appointments.

INSURANCE

We participate with most health insurance plans. We recommend that you check with your insurance company to determine health care coverage.
You are expected to pay your deductible and co-payments at the time of service. If we have not received payment from your insurance company within 45 days of the date of service, you will be expected to pay the balance in full. You are responsible for all charges.

We do not bill secondary insurance companies or insurance companies we do not participate with and/or not except assignment from. Your time of service receipt includes all information necessary for submitting claims to your insurance company.

If you need assistance or have questions, please contact our Billing Office, Peds One, at 866 371-6118.

REFUNDS

Overpayments will be refunded upon written request to the responsible party within 30 days.

MANAGED CARE

If you are enrolled in a managed care insurance plan (e.g.: a HMO), you must receive a referral from our office *before seeing a specialist*. **NO** retroactive referrals will be given.

MISSED APPOINTMENTS/LATE CANCELLATIONS

Broken appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. Cancellations are requested 24 hours prior to the appointment. We reserve the right to charge for missed or late canceled appointments: $75 missed appointment fee for well visits and $50 for all others. Excessive abuse of scheduled appointments may result in discharge from the practice.

I have read and understand the Westside Pediatrics P.C. Financial Policy. I agree to assign insurance benefits to the Westside Pediatrics P.C. practice 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 fee charged by the collection agency for costs of collections.

Signature: _____

Print Name: _____ Date: _____

✪ Please remember, it is your responsibility to have an understanding of the benefits your insurance company offers