

Patient Name \_\_\_\_\_ Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_  M  F Born at \_\_\_\_\_ Hospital \_\_\_\_\_

Patient Address \_\_\_\_\_ Daytime Phone (\_\_\_\_) \_\_\_\_\_  
No. Street City State Zip

**BILLING**

Parent/Guardian #1 \_\_\_\_\_ Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_  
No. Street City State Zip

Employed By \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_

Cell (\_\_\_\_) \_\_\_\_\_

Parent/Guardian #2 \_\_\_\_\_ Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_  
No. Street City State Zip

Employed By \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_

Cell (\_\_\_\_) \_\_\_\_\_

Other Children: \_\_\_\_\_ B.D. \_\_\_\_/\_\_\_\_/\_\_\_\_ \_\_\_\_\_ B.D. \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_ B.D. \_\_\_\_/\_\_\_\_/\_\_\_\_ \_\_\_\_\_ B.D. \_\_\_\_/\_\_\_\_/\_\_\_\_

Who Referred You to Our Office? \_\_\_\_\_ Previous Doctor \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

**INSURANCE**

Insured's Name \_\_\_\_\_ SS # \_\_\_\_\_ B.D. \_\_\_\_/\_\_\_\_/\_\_\_\_ Group # \_\_\_\_\_

Insurance Company \_\_\_\_\_ Address \_\_\_\_\_

2nd - Insured's Name \_\_\_\_\_ SS # \_\_\_\_\_ B.D. \_\_\_\_/\_\_\_\_/\_\_\_\_ Group # \_\_\_\_\_

Insurance Company \_\_\_\_\_ Address \_\_\_\_\_

**FINANCIAL AGREEMENT** *(Read before signing)*

I understand that fees are payable when service is rendered unless Columbia Pediatric's physicians are contracted with my insurance company and my insurance company will pay all fees at 100%. I understand that I am responsible for all non-covered services, co-insurance fees and co-payments.

I understand that for any reason it is necessary to carry a balance on my account, interest will be charged on any balance over ninety (90) days.

I understand that if my account is turned over to a collection agency, my child/children will no longer be treated by the physicians at Columbia Pediatrics Medical Group, Inc.

I have read and understand Columbia Pediatric's "Notice of Privacy Practices" regarding the uses and disclosures of my child's health information.

Signature \_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Signature \_\_\_\_\_ Relationship to Patient \_\_\_\_\_