CHILDREN'S MEDICAL GROUP, P.C.

Do you have any other children that come to this office? If so, what are their names?

Patient's Name : DOB : Sex :

Male

Female

Address : City : State : Zip : Home Phone :

Father's Name : DOB : Father's DL# :

Father's SS# : Cell Phone : Work Phone :

Employer :

Mother's Name : DOB : Mother's DL# :

Mother's SS# : Cell Phone : Work Phone :

Employer :

Responsible Party : Relationship to Patient :

E-mail :

Name of Nearest Relative (other than parents) :	Relationship to Patient :	Phone Number :

Primary Insurance :

Contract # / ID # :

Policy Holder's Name :

Group # :

Policy Holder's DOB :

Secondary Insurance :

Contract # / ID # :

Policy Holder's Name :

Group # :

Policy Holder's DOB :

Please present your insurance card(s) at the time of visit.

All so-payments, deductibles, and percentages are due at the time of service. After the first visit, any arrangements are to be made with the business office. In consideration of the services furnished and to be furnished by CHILDREN'S MEDICAL GROUP, I(we) hereby guarantee to CHILDREN'S MEDICAL GROUP the payment of the account for services rendered to said patient (together with previously incurred and your unpaid charges). I(we) agree to pay these accounts when due. For the payment for such accounts, I(we) hereby waive all claims of exemption and agree to pay a reasonable attorney's fee for the collection of these accounts, if places in the hand of an attorney for collection. I(we) assign insurance benefits to Children's Medical Group and authorize release of information to my insurance company.

ESignature (Full Name) :

Date :

Non-Covered Services Statement

As your child's provider, I want to provide my patient with the best care possible. There are services that I feel are necessary for the treatment of your child's condition and maintenance of good health that may not be covered by your health benefits contract. Should your insurance not cover these services, you are expected to pay for those services in full.

Let me reassure you that i will order only the tests and treatments that i feel are necessary for your child's treatment and care.

If you have any questions about whether or not a particular service is covered by your health benefits contract, someone in our office will be happy to assist you. Thank you for understanding.

POSSIBLE NON-COVERED SERVICES
(financially responsible party)

- preventive care
- vaccines
- gardasil
- hearing/vision screenings
- hematocrit/CBC/blood draw
- menactra
- urinalysis
- med/ortho supplies
- other ____________

I have read your policy and agree to pay for the services outlined below that are not covered by my contract as a indicated below.

ESignature (Full Name) :