PONTCHARTRAIN PEDIATRICS, LLC

Account # **Email Address:**

GUARANTOR INFORMATION

Father's Name	**Mother's Name**
Home Address	Home Address
City/State/Zip	City/State/Zip
SS #	SS #
Home Phone	Home Phone
Cell Phone	Cell Phone
Work Phone	Work Phone
Employer	Employer
Driver's Lic. #	Driver's Lic. #
Birth Date	Birth Date

PATIENT INFORMATION

Patient's Last Name _____ **First** _____ **Middle** _____

Home Address _____

City/State/Zip _____

Birth Date _____ Sex M or F (circle one) Race _____

Relation to Guarantor _____ SS # _____

INSURANCE INFORMATION

Primary Insurance

Subscriber's Name (Person who carries the policy) _____

Insurance Company Name _____

Secondary Insurance

Subscriber's Name (Person who carries the policy) _____

Insurance Company Name _____

PHARMACY INFORMATION

Pharmacy Name _____ Phone _____ Fax _____

Other children that are patients of **Pontchartrain Pediatrics, LLC:**

_____ _____

_____ _____

Emergency Contact: _____ **Phone #:** _____

I hereby authorize and direct payment of my medical benefits to Pontchartrain Pediatrics for any service furnished to me by the physicians. I understand that I am financially responsible for any non-covered services. I also give authorization to release to my insurance company any information needed to process claims.

X _____ _____

Signature of Guarantor **Date**

PONTCHARTRAIN PEDIATRICS
4405 HWY 190 SERVICE RD.
COVINGTON, LA 70433
985-893-8505
985-893-0093 FAX

DATE:_____

CHILD:_____

I, _____ AUTHORIZE THE FOLLOWING TO CONSENT TO TREATMENT OF MY CHILD. I WILL NOTIFY YOU IF ANY CHANGES ARE MADE TO THE NAMES ON THIS LIST.

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

SIGNATURE:_____

PRINT: _____

RELATIONSHIP: _____

No Show Fee $25.00

_____
sign

Interest 10% on all balances over 90 days

_____
date

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

I acknowledge that I have received the attached Privacy Notice.

_____ _____
Patient or Personal Representative Signature Date

If Personal Representative's signature appears above, please describe Personal Representative's relationship to patient:

_____

Pontchartrain Pediatrics, LLC
Financial Policy Agreement
and Consent to Evaluate and Treat

We believe that everyone benefits when there is a clear and definite understanding of our financial policy prior to treatment.

1. ALL PATIENTS WITH MANAGED CARE PLANS: It is your responsibility to know and understand your Managed Care plan. Generally, these plans require payment of deductibles and/or co-payments at the time of service.

2. ALL PATIENTS WITH INSURANCE: Our office will file your insurance if you provide us with the proper information. You will be expected to pay any balance not covered by your insurance company at the time of service. If your insurance overpays, we will refund you promptly if requested in writing by the insured. Otherwise, overpayments will be credited to your account for future services. If your insurance company does not pay within 60 days, you are responsible for the remaining balance and will be billed accordingly.

It is your responsibility to monitor your benefits and annual maximum. We will be happy to assist you with any resubmission of charges to your insurance carrier.

3. PATIENTS WITHOUT INSURANCE: All patients without insurance are expected to pay the entire fee at the time of service unless other arrangements were made in advance with our office.

4. QUESTIONS: You are encouraged to call our office if there are any questions about this information. If at any time during the course of treatment problems with this financial policy arise, you are encouraged to speak with our office.

FOR YOUR CONVENIENCE WE ACCEPT CASH OR PERSONAL CHECKS.

I have read and agree with these terms.

Responsible Party's Signature: _____ Date: _____

Witness' Signature: _____ Date: _____

I authorize the release of any medical or other information necessary to process insurance claims or to send to a collections agency. If you are using insurance, please sign below to assign benefits to Pontchartrain Pediatrics for all visits:

Insured Party's Signature: _____ Date: _____

Patient Name: _____ Date of Birth _____

I authorize the doctors of Pontchartrain Pediatrics, LLC to evaluate and treat _____

Signature: _____ Date: _____

Relationship to Patient: _____

Witness: _____ Date: _____

Print Form