CORNERSTONE PEDIATRICS ASSOCIATES, INC

Today's date _____

RESPONSIBLE PARTY (parent who carries insurance)

Name _____ Birth Date _____

Street Address _____

City _____ State _____ Zip _____ Cell# _____

Home Phone _____ Work Phone _____

Relationship to patient _____ Employer _____

SS# _____ Occupation _____

SELF

Name _____ Birth Date _____

Street Address _____

City _____ State ___ Zip _____ Cell # _____

Home Phone _____ Work Phone _____

SS# _____ Employer _____

Email address _____

EMERGENCY CONTACT (Relative or friend living with you)
Name _____ Relationship _____
Phone _____

PLEASE READ AND SIGN THE OTHER SIDE

I give permission for _____to make medical transactions for me
(Parent Name)
as well as accessing all of my medical records, for the period of 1 physical year.

CORNERSTONE PEDIATRIC ASSOCIATES POLICIES

1. A copy of the patient's insurance card is required on each and every visit to us. It is the patient's responsibility to make sure that any insurance information given to our office is correct and current. Failure to provide such information will result in patient financial responsibility for all services. It will be my responsibility to list a physician if my insurance requires a PCP, and call for a referral if one is required. _____

2. Co-payments are due at the time of service. We may ask that non-emergent appointments be rescheduled if co-payment is not paid. _____

3. I understand that I am responsible for all charges incurred in this office, less any contracted insurance rates adjustments, in accordance with the regular (published) rates and terms of the office, regardless of insurance coverage. All deductibles, co-payments and co-insurances are due at the time of service. It is your responsibility to know you insurance coverage prior to your child's appointment. _____

4. We are not party to any legal agreements between divorced or separated parents. _____

5. All unpaid balances after being processed by insurance will incur a rebilling fee of $5.00 per month after 30 days. Should the account be referred for collection, you shall pay actual attorney's fees, collection expenses, and court costs. IF YOUR ACCOUNT IS REFERRED FOR COLLECTION, THE PRINCIPAL BALANCE WILL BE INCREASED BY 25%. _____

6. I understand that Cornerstone Pediatrics Assoc. requires that I carry a credit card on file. If the credit card I provide is declined; I understand that I will be charged an extra $50.00 reprocessing fee. _____

7. I understand that if well child visits and immunizations are not covered by my plan I am responsible for paying for these visits at the time of service. Please note that some insurance carriers have a maximum on well coverage. Please verify your benefits. _____

8. If insurance is billed on my behalf by Cornerstone Pediatrics, I authorize my insurance company to make payments directly to them. I authorize the release of any medical information necessary to process claims and/or pursue payment of this account. _____

9. I understand I will be billed for missed appointments. I may be asked to reschedule if I am more than 10 minutes late for appointment. _____

10. Daycare, camp, sports and school forms require 5 business days to complete. _____

11. If your insurance carrier requires a referral to a provider outside our office you must contact our referral department 5 business days prior to an appointment. Failure to do so may result in you being financially responsible for those services provided by another office. _____

12. I understand a credit card or health savings account card will be kept on file and billed once insurance settles (approximately 6 days after your visit). _____

13. I understand that as an 18 year old adult, I am now responsible for all medical bills. _____

_____ _____ _____

Signature of patient Date

Updated 09/07/17