Medical Arts Pediatrics, PLC - 2008 Information Update

Please provide us with the following information. **Insurances require current information and a signature to submit a claim.** Please give your insurance card to the front desk with this form. Our goal is to offer your child the best possible health care. Thank you for working with us to obtain this goal

Please Print **Today's Date** _____

Child's Information

Name _____
First Middle Initial Last

Date of Birth _____ Home Phone _____

Address _____

City _____ State _____ Zip _____

Social Security # _____ Sex: M F

Emergency Contacts - Other than parents

Name _____

Phone _____ Relationship _____

Name _____

Phone _____ Relationship _____

Primary Insurance

Name of Insurance _____

Copy of Card on File: Yes No Date _____

Subscriber's Name _____

Subscriber Date of Birth _____ Sex: M F

Relationship to Child _____

Secondary Insurance

Name of Insurance _____

Copy of Card on File: Yes No Date _____

Subscriber Name _____

Subscriber Date of Birth _____ Sex: M F

Relationship to Child _____

Mother/Gaurdian Name _____ Address _____
If different than child's address above

Date of Birth _____ City _____ State _____ Zip _____

Social Security # _____ Cell Phone _____ Home Phone _____

Employer _____ Work Phone _____

Father/Guardian Name _____ Address _____
If different than child's address above

Date of Birth _____ City _____ State _____ Zip _____

Social Security # _____ Cell Phone _____ Home Phone _____

Employer _____ Work Phone _____

Note Regarding Your Insurance: Please do not expect the staff to know the terms, conditions, limitations and exclusions of your health plan. **This is your responsibility.** We are happy to bill your insurance company if all the correct information is provided. The person bringing your child in is responsibile for your payment/copay. **Your copay is due at the time of your visit.** If the copay is not paid at the time of the visit, a service charge may be applied to your account.

I _____ request payment of authorized benefits to be made on my behalf to Medical Arts Pediatrics, PLC (MAPeds)
Please Print Parent/Guardian Name

for services rendered to me or my minor child. I authorize MAPeds and their affiliated medical providers to release my/my child's medical information to our stated insurance carrier and its agents to determine benefits and/or the benefits payable for related services. **I understand that I am financially responsible for any balance not covered by my insurance carrier. I also understand that my copay is due at the time of service.** Finally, I acknowledge that I have been made aware of MAPed's HIPAA Privacy Policies by viewing them in their office and/or have received a written copy.

Signature _____ **Relationship** _____ **Date** _____