

SUMMIT PEDIATRIC PULMONOLOGY, LLC

33 Overlook Road, Suite 207

Summit, NJ 07901

Phone: 908-273-2300

Fax: 908-273-4320

PATIENT INFORMATION

PATIENT'S LAST NAME _____ FIRST NAME _____ DOB _____ SEX M F

MAILING ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

HOME TEL (____) _____ CELL (____) _____ Email _____

PARENT/GUARDIAN INFORMATION

PARENT LAST NAME _____ FIRST NAME _____ DOB _____

ADDRESS (IF DIFFERENT FROM ABOVE) _____

CITY _____ STATE _____ ZIP _____ WORK TEL (____) _____

SS# _____ EMPLOYER _____

PARENT LAST NAME _____ FIRST NAME _____ DOB _____

ADDRESS (IF DIFFERENT FROM ABOVE) _____

CITY _____ STATE _____ ZIP _____ WORK TEL (____) _____

SS# _____ EMPLOYER _____

INSURANCE INFORMATION (PLEASE PRESENT INSURANCE ID CARD TO RECEPTIONIST)

[] SELF PAY

[] PRIMARY INSURANCE COMPANY _____

ID # _____ GROUP # _____

NAME OF POLICY HOLDER _____

PRIMARY CARE PHYSICIAN (REPORTS WILL BE SENT TO THIS PHYSICIAN UNLESS OTHERWISE SPECIFIED)

MD NAME _____ PHONE _____

ADDRESS _____ FAX _____

IN CASE OF EMERGENCY, PLEASE LIST A CONTACT PERSON (PLEASE LIST A CONTACT OTHER THAN PARENTS)

NAME _____

HOME PHONE _____ WORK/CELL PHONE _____

RELATIONSHIP TO PATIENT _____

We are committed to providing you with the best possible care and pleased to discuss fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your financial responsibility.

PLEASE REMEMBER THAT INSURANCE IS CONSIDERED A METHOD OF REIMBURSING THE PATIENT FOR FEES PAID TO THE DOCTOR AND IS NOT A SUBSTITUTE FOR PAYMENT. SOME COMPANIES PAY FIXED ALLOWANCES FOR CERTAIN PROCEDURES AND OTHERS PAY A PERCENTAGE OF THE CHARGE. IT IS YOUR RESPONSIBILITY TO PAY ANY COPAYS, DEDUCTIBLE, COINSURANCE OR ANY OTHER BALANCE NOT PAID BY YOUR INSURANCE COMPANY.

- **REFERRALS**- If your plan requires a referral from your PCP (Primary Care Physician), it is your responsibility to obtain it prior to your appointment and to have it with you at the time of your visit. If you do not have your referral, you will be personally responsible for that day's services.
- **CO-PAYMENTS**- By law we must collect your carrier designated co-pay. This payment is expected at the time of service. Please be prepared to pay the co-pay at each visit. Should you not pay at the time and we send you a statement, an administrative fee of \$20.00 may be added to your account.
- **INSURANCE PLANS**- You will be responsible for any balance your plan indicates as due on their EOB "Explanation of Benefits". All patients will be responsible for their co-insurance and deductibles.
- **DIVORCED/SEPERATED PARENTS OF MINOR PATIENTS**- The parent who consents to treatment of a minor child is responsible for payment of services rendered, this office will not be involved with separation or divorce disputes.

You are responsible for the timely payment of your account. Should it become necessary for us to use an outside agency to collect payment from you, you will be charged additional fees.

I AUTHORIZE THE RELEASE OF ANY INFORMATION NECESSARY TO DETERMINE LIABILITY FOR PAYMENT AND TO OBTAIN REIMBURSEMENT ON ANY CLAIM.

I REQUEST THAT PAYMENT OF AUTHORIZED BENEFITS BE MADE ON MY BEHALF. I ASSIGN THE BENEFITS PAYABLE TO WHICH I AM ENTITLED, INCLUDING MEDICARE, PRIVATE INSURANCE AND OTHER HEALTH PLANS TO THE PRACTICE. THIS ASSIGNMENT WIL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING. A PHOTOCOPY OF THIS ASSIGNMENT IS TO BE CONSIDERED AS VALID AS THE ORIGINAL.

I UNDERSTAND THAT I AM FINACIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY SAID INSURANCE.

THANK YOU FOR YOUR COOPERATION

BY SIGNING BELOW, YOU CONFIRM THAT YOU HAVE READ AND UNDERSTAND THE ABOVE:

NAME OF PERSON RESPONSIBLE FOR CHARGES: _____

SIGNATURE _____ **RELATIONSHIP** _____ **DATE** _____

Acknowledgement of Receipt of Notice of Privacy Practices

I have been presented with a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law, outlining my rights regarding my health information.

Signed _____ Date _____

Relationship to patient _____

I wish to place the following restrictions on disclosure of my health information:

Internal use only:

If patient/patient's representative refuses to sign acknowledgment, please document date and time notice was presented to patient/patient's representative and sign below:

Presented on (Date & Time) _____ By: (Name & Title) _____