# PALM BEACH PEDIATRIC GASTROENTEROLOGY

## PATIENT INFORMATION

| Patient's Last Name | First Name | ☐ Male ☐ Female | Date of Birth |
|---|---|---|---|
| | | | |

| Street Address | Apt | City | State | Zip |
|---|---|---|---|---|
| | | | | |

| Patient's Race (or Multi racial) | Ethnicity ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Prefer not to disclose |
|---|---|
| | Patients Social Security Number |

| *Pediatrician or Group* | Phone Number | Pharmacy / Phone |
|---|---|---|
| | | |

## PARENT/GUARDIAN INFORMATION

| Parent's Name (First and Last) | Parent's Name (First and Last) |
|---|---|
| Date of Birth | Date of Birth |
| Address (if different than child) | Address (if different than child) |
| Email Address | Email Address |
| Cell Phone | Cell Phone |
| Employer<br>Address | Employer<br>Address |
| Work Phone | Work Phone |
| Occupation | Occupation |
| Social Security Number | Social Security Number |

| Persons authorized to bring patient or speak by phone | How did you select our practice? ☐ Web Search<br>☐ Physician Referral Name _____<br>☐ Friend recommendation ☐ Other |
|---|---|
| | |

## INSURANCE INFORMATION

| Insurance Company | Policy #/Member ID | Group # |
|---|---|---|
| | | |

| Name of Primary Insured | Date of Birth | Patients Relationship to Subscriber<br>☐ Self ☐ Child ☐ Other |
|---|---|---|
| | | |

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## PAYMENT AND PRIVACY POLICIES

I understand that payment is required at the time services are rendered, unless prior arrangements have been made.

### Assignment of Medical Benefits

I hereby assign all medical benefits (claim payments from insurance) to Palm Beach Pediatric Gastroenterology. I authorize release of medical records necessary to process claims.

### Agreement to Pay

In consideration of the services rendered to the patient, I do hereby agree and obligate myself to promptly pay Palm Beach Pediatric Gastroenterology any co-payments, co-insurance and deductibles. I also agree to pay any legitimate claim rejected or otherwise not paid by insurance. In addition, I agree and obligate myself to pay all collection costs, court costs and attorneys' fees that may arise from payment default. If the amount owed is not fully satisfied by the due date, then a fee of 35% of the outstanding balance (as calculated on the due date) will be added to the outstanding balance.

I understand that I may be responsible for a "No Show" fee of up to $50 for failure to keep an appointment without providing at least a 24 hour advance notice of cancellation. This fee is not covered by insurance and will be billed directly to me.

### Returned Check Charge

There is a service charge of fifty dollars for all checks returned unpaod by your bank

### Acknowledgement of Privacy Policy

I have received a copy of the Notice of Privacy Practices

I agree that Palm Beach Pediatric Gastroenterology may obtain the patient's medication history from all pharmacies used.

I have read, understand and agree with all of the above.

Your Name _____ Relation to Patient _____

Signature _____ Date _____