Silverton Pediatrics
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Patient Identification Data- 18 Years and Older

Patients Name: ______________________ **Date of Birth:** ____________

Any Known Allergies: ______________ **Email:** ______________________

Cell Phone(Primary Phone): ______________ **HomePhone:** ____________

Address: ______________________ **City:** ________ **State:** ______ **Zip:** ______

Father's Name: ________________ **DOB:** ________

CellPhone: ________________ **Home Phone:** ________________

Address: ______________________ **City:** ________ **State:** ______ **ZIP:** ______

Mother's Name: ________________ **DOB:** ________

Cell Phone: ________________ **Home Phone:** ________________

Address: ______________________ **City:** ________ **State:** ______ **ZIP:** ______

Medical Information Release:

I authorize the following individual(s) to make decisions/obtain information on my behalf regarding my medical care and or account:

Name: ______________ Relationship: ________ Phone: ____________

Name: ______________ Relationship: ________ Phone: ____________

Name: ______________ Relationship: ________ Phone: ____________

In case of emergency and we need to contact you but are unable to reach you at the phone numbers you have previously listed, please provide us with an alternate contact i.e. grandparents, friend, neighbor.

Name: ______________ Relationship: ________ Phone: ____________

Signature: ______________________________ **Date:** __________

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Patient Identification Data 18 years and older

* Financial Policy *

Mission Statement: *Within the framework of a healing environment, we offer effective and efficient care to our patients and families in the growing and changing world. We strive to meet our goals with compassion, competence, courtesy and confidentiality. As we embrace new concepts to improve medical care, we will keep the welfare of our patients as our number one priority.*

Because health care costs have increased for the physician and insurance rules have become more stringent, we find it necessary to emphasize our financial policy. In an effort to keep your medical costs down, and in fairness to all our patients, we have decided not to raise our fees at this time, but instead, to require a signature that you acknowledge and agree to the following financial policy.

- Your bill is your responsibility unless you have an insurance policy with a company with which we are members, and it is otherwise stated in our contract with that company.
- Payments, including co-pays, are expected at the time of service.
- Payment may be made by cash, check, Visa, Mastercard, American Express, Discover, or MAC (or other bank debit cards).
- If you need to pay by post-dated check, please discuss this option with the front desk person when you first approach the desk, before your bill is put into the computer.

Insurance

- All co-pays must be paid at the time of service.
- If we are members of your insurance company, carrying your specific policy, we will file the claim for services.
- After we receive the explanation of benefits (EOB), you will be billed for the portion of the charges that the insurance company states is your responsibility.
- If we are not members of your insurance company or not members for your specific policy, we will provide you with a time of service receipt, showing your payment, which includes all the information you need to process your claim. Just attach it to your claim form.

Missed Appointments

- If you arrive 20 minutes late for an appointment, we may ask you to reschedule.
- If 3 appointments are missed within a 6 month period, we regret that we may not be able to keep you on as a patient.
- A well/physical exam must be canceled 24 hours prior to appointment, if not there will be a no show charge of $30.00.
- An acute care or sick visit must be canceled 2 hours prior to the appointment.

Assignment of Benefits

I understand that my signature requests that payment be made to the physician and that it authorize release of medical information necessary to pay the claim to physician.

Signature:____Date:____________________