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):**_____

**Address:**_____ **City:**_____ **State:**_____ **Zip:**_____

**Father's Name:**_____**DOB:**_____

**CellPhone:**_____

**Address**:_____**City:**_____**State:**_____**ZIP:**_____

**Mother's Name:**_____**DOB:**_____

**Cell 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**:_____

## Silverton Pediatrics

### *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, regardless of who brings the child to our office.
- 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. You may do this automatically by signing a statement that we may charge it to you Visa/MC or you may wait for us to bill you.
- If we are members of your secondary insurance company, we will be happy to submit to your primary company if you provide us with a completed and signed claim form at each time of service.
- 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, which includes all the information you need to process your claim. Just attach it to your claim form.

### *Assignment of Benefits*

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

Signature:_____ Date:___/___/_____