Silverton Pediatrics
Rumana Qazi, M.D. Shirley Ulep, M.D.
Chris Patestos, M.D. Valerie May Sia, M.D.
Mariane Ibrahim, M.D Reza Razvi D.O
1314 Hooper Avenue Bldg A, 2nd Floor
Toms River, NJ 08753
T: 732-255-7553 F:732-255-8901

Please List All Children

First Name	Last Name	DOB	Allergies

Primary Address: _____ **Primary Cell:**_____
City:_____ **State:**_____ **ZIP:**_____
Family Email Address:_____
Name of Current/ Previous Physician:_____

Parent Name:_____ **DOB:**_____ **Cell Phone:**_____
Address:_____ **City:**_____ **State:**_____ **ZIP:**_____
Occupation:_____ **Employer:**_____ **Work Phone:**_____

Parent Name:_____ **DOB:**_____ **Cell Phone:**_____
Address:_____ **City:**_____ **State:**_____ **ZIP:**_____
Occupation:_____ **Employer:**_____ **Work Phone:**_____

Emergency Contact: Name:_____ **Phone:**_____

In case of emergency and you are unable to bring the children into the office please list who you give consent on your behalf to bring them in and make medical decisions on your behalf:

First Name	Last Name

Signature:_____ **Date**:_____

Print Name/Relationship To Patient(s):_____

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:___/___/_____

Divorce

In case of divorce, the divorce papers are an agreement between you and your ex-spouse. The person who brings the child to the office is responsible for the bill at the time of service.

Unscheduled Visits

If you want more than one child to be seen by the doctor, you must tell us before you arrive. Surprises cause long waits and unhappy patients. Please be considerate.

Missed Appointments

We are trying our best to accommodate your needs. You can help us by keeping your appointment and arriving on time.

- 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 check-up or "well" visit must be canceled 24 hours prior to the appointment.
- An acute care or "sick" visit must be canceled 2 hours prior to the appointment.

Baby-Sitters

If it is necessary for someone other than a parent to bring your child to the office, you must send a note explaining who has permission to do so.

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:_____ Phone:(___)_____

Thank you for entrusting the care of your child to us at Silverton Pediatrics. If you have any questions regarding our financial policy, please contact the front office. We are happy to serve you.

"I have read, understand, and agree to the provisions of this financial policy."
"I have received a copy of Silverton Pediatrics, LLC Privacy Policy."

Signature:_____ Date:___/___/_____

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List Children's Name: _____ _____ _____

_____ _____ _____

Insurance Information

Primary Insurance:

Name of Plan: _____

ID #: _____ Group #: _____

Policy Holder Name: _____ Policy Holder DOB: _____

Employer: _____ Effective Date: _____

Secondary Insurance:

Name of Plan: _____

ID #: _____ Group #: _____

Policy Holder Name: _____ Policy Holder DOB: _____

Employer: _____ Effective Date: _____

Assignment of Benefits
I understand that my signature requests that payments be made to the physician, and that it authorizes release of medical information necessary to pay the claim to the physician.

Print Name/Relationship To Patient(s): _____

Signature: _____ Date: _____

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Patient Portal Request Form

Parent/Guardian Name: _____

Email Address: _____

Phone Number: _____

Patient Name & DOB: _____

_____

_____

_____

_____

_____

Print Name & Relationship to Patient(s): _____

Signature: _____ Date: _____