Silverton PEDIATRICS

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

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 & Last Name	Phone Number

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.*
- 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 of 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.
- If we are not 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 claims form at each service.

Assignment of Benefits

- I understand that my signature requests 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 into the office is responsible for the bill at 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.

Quality of Care

To stay active in our practice, our office policy is to maintain a yearly well visit.

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 30 minutes late for an appointment, we may ask you to reschedule.
- If 3 appointments are missed within a 6 month period, we regret 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.
- All other visits must be canceled 2 hours prior to the appointment, if not there will be a no show charge of $30.00.

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:_____

List Children(s) Name(s): _____ _____ _____

_____ _____ _____

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: _____