Today's date: ______ / ______ / ______

PLEASE LIST ALL CHILDREN FROM YOUR FAMILY

Patient names: Date of birth:

____ ______ / ______ / ______

____ ______ / ______ / ______

____ ______ / ______ / ______

____ ______ / ______ / ______

Parent 1: Name __________________________ Phone Number: ______________________

Parent 2: Name __________________________ Phone Number: ______________________

Home Address: ____ Apt: __________

City: ________________________________ State: ________ Zip Code: ____________

Billing Address (if different from Home Address): ___________________________ Apt: _______

City: ________________________________ State: ________ Zip Code: ____________

Which method of communication would you prefer for our **Patient Portal** for access to forms, online bill paying, and secure communication with our office? ☐ Email _____________________ ☐ Cell # ____________

PLEASE COMPLETE BOTH SIDES

Tender Care Pediatrics PC

FINANCIAL POLICY

Thank you for choosing Tender Care Pediatrics as your child's health care provider. The following is a summary of our financial policy. Patient care is not permitted without the written consent of the receipt and acknowledgement of the understanding of this policy.

Payments: Payment, in full, is due at the time of service. This includes applicable co-pays, co-insurance and payments for services not covered or denied by the insurance company. Tender Care Pediatrics accepts cash, personal check, debit cards, and all major credit cards. ______(initials)

Self-Pay Accounts: If you do not have insurance, please come prepared to pay for your visit in full upon check-out. We offer a 40% discount for all self-pay services paid in full on the day of the service. ______(initials)

Missed Co-Pays: Tender Care Pediatrics is required by our insurance contracts to collect all co-pays at the time of service. Failure to collect co-pays put the responsible party and Tender Care Pediatrics in default of the insurance contract. A $20 service fee will be charged in addition to your co-payment if the co-payment is not paid by the end of that business day. ______(initials)

Missed appointments: Missed appointments represent a cost to us, you, and to other patients that could have been seen during the time set aside for your child. Cancellations are required 24 hours prior to any well visit appointment and 2 hours prior to any sick visit appointment via phone call to the practice. A "no show" fee will be applied if an appointment is missed and not cancelled within the stated time frame. ______(initials)

Out of Pocket Costs: We pride ourselves on providing only the highest quality care for your child and follow AAP clinical guidelines for screenings, labs, and procedures. If your health insurance plan does not cover these costs you will be responsible for payment. ___(initials)

After hours and Holidays: We code for visits outside of our regularly scheduled hours. Your insurance may make you responsible for payment. ___(initials)

Outstanding Balances: If you have a personal balance on your account, a monthly statement will be sent. Unless authorized in writing, payment is due upon receipt of statement or within 30 calendar days. ______(initials)

Payment Plans: Tender Care Pediatrics understands that full payment may not be possible in certain circumstances. As a courtesy, Tender Care Pediatrics may offer the assigned account holder a payment plan. Payment plans are approved on a case-by-case basis and may be discussed with our management team. Patients with a payment plan must be in full compliance with all conditions of the agreement at time of visit. Failure to make scheduled payments on the payment plan, or not paying off a balance in full, may result in your account being turned over to a collection agency and your family being dismissed from the practice. ______(initials)

Collection Accounts: If your account is submitted to a collection agency, all associated fees are the responsibility of the assigned account holder, including a collection fee equal to 40% of the collection balance. The assigned account holder will receive written notification by way of a dismissal letter given 30 calendar days to find a new health care provider. ______(initials)

Returned checks: A $25 fee will be charged for any checks returned for insufficient funds. ______(initials)

Insurance: We accept most insurances including Medicaid plans. Please contact your insurance company to verify we are listed as a contracted provider before scheduling an appointment if you are unsure. Please bring a copy of your insurance card to every visit. A scanned copy of the assigned account holder's current insurance card and driver's license is required to be kept on file. Please present newly issued insurance cards upon check-in at the next scheduled visit. If we cannot confirm that one of our providers is listed as your child's PCP, we will ask that the appointment be rescheduled. ______(initials)

Change of Insurance/Change of Account Information: Please notify the office as soon as possible of any and all account changes, including co-pay amounts, insurance updates, and change of mailing address. If the account holder does not notify the office within 15 calendar days of these changes, the assigned account holder becomes responsible for any and all charges. ______(initials)

Review and consent of this policy is required prior to services rendered.

Patient's first name: ______________________ Last Name: ______________________ Birth date: ___/___/___

My initials above and signature below certifies that I have read and consent to the outlined policies and procedures.

______________________ ______________________ Date:___/___/___

Signature of parent/guardian **Printed name of parent/guardian**