Willow Bend Pediatrics

Patient Information

Name: _____Middle:_____Last:_____Suffix:_____
Address:_____ City:_____ State:_____ Zip:_____
Sex: M / F DOB:_____/_____/_____
How did you hear about us: _____

Policy Holder & Insurance Information

Name: _____Middle:_____Last:_____Suffix:_____
Address:_____ City:_____ State:_____ Zip:_____
Sex: M / F DOB:_____/_____/_____
Marital Status: _____ Relationship to Patient: _____
Employer:_____ Occupation: _____
Primary cell#: _____ Secondary cell#_____

Primary email: _____ Secondary email: _____

Insurance Company:_____
Insurance Company Address:_____ City: _____ State: _____ Zip: _____
Subscribers I.D. #: _____ Group #: _____
Insurance Company Phone Number: _____

(Please provide your ID card and Driver's License with this information)

Parent / Legal Guardian

Parent / Legal Guardian: (If different than Guarantor Information)
Relationship to Patient: _____
Name: _____Middle:_____Last:_____Suffix:_____
Address:_____ City:_____ State:_____ Zip:_____
Sex: M / F DOB:_____/_____/_____
Marital Status: _____ Relationship to Patient: _____
Employer::_____ Occupation: _____
Phone: _____ Work: _____ Mobile: _____
Email: _____

Authorized Person to seek medical care for your child on your behalf

Name: _____Middle:_____Last:_____DOB:_____

Cell: _____ Relationship to you: _____

Email: _____ DL# _____

Please complete both sides of this form.

Siblings that attend Willow Bend Pediatrics

Name:_____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

Responsible Party

I warrant that I am the party responsible for making medical decisions for the child represented in this medical record. I acknowledge payment is due at the time services are rendered, unless other arrangements have been made. I understand the Responsible party is considered the **"Custodial Parent "**for the child/children and not the **"Insured Party"**. The address on your account will be the primary residence of the child and will be used for billing purposes and any other correspondence from our office. Forwarding statements and recovering outstanding balances by the **"Non-Custodial Parent"** due to court order, is the responsibility of the **"Custodial Parent"**. Our office does not have the authority to enforce a **"Non-Custodial"** parent to pay an outstanding balance. I understand that Willow Bend Pediatrics will not get involved in matters involving third party personal billing whether result of custody, court order or personal circumstances.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I acknowledge by signing this form that I have received a copy of the Notice of Privacy Practices.

Assignment and Release

I hereby authorize payment directly to Willow Bend Pediatrics of all insurance benefits otherwise payable to me for the services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents. I authorize Willow Bend Pediatrics to release information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party:_____ Date: _____

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