Print

WILSON PEDIATRICS

Information Sheet

Mother _____DOB_____

Address_____City_____ St _____Zip_____

Cell Phone_____Home Phone_____Work:_____

Employer Name & Address_____

Married ☐ Single ☐ Divorced ☐ Pharmacy of Choice _____

Email_____

Father_____DOB_____

Address_____ City_____ St _____Zip _____

Cell Phone_____Home Phone_____Work:_____

Email_____

Employer Name & Address _____

Married ☐ Single ☐ Divorced ☐ Pharmacy of Choice_____

Children:

_____ M ☐ F ☐ DOB_____

_____ M ☐ F ☐ DOB_____

_____ M ☐ F ☐ DOB_____

Insurance Company _____Policy ID _____Group ID _____

I hereby authorize Wilson Pediatrics to furnish information to insurance carriers concerning my children's illnesses & treatments, and I hereby assign to the physician all payments for services rendered. I understand I am responsible for any amount not paid by my insurance company including co-pays and deductibles. If my insurance company does not pay my claim in a timely manner, I will pay for services and wait for my insurance company to reimburse me. If collections proceedings become necessary, I agree to become responsible for costs incurred in collecting any outstanding balance due. I have read the "Notice of Privacy Practices" that is posted in our waiting room and if requested, I have received a copy of this notice.

FINANCIALLY RESPONSIBLE PARTY:_____

Signature_____Date_____

OUR PRACTICE POLICIES

We are dedicated to providing the best possible care for your children, and we want you to completely understand all of our policies.

Payments:
Payment is due at the time of service, (including co-pays and deductibles) We accept MasterCard, Visa, Discover, checks and cash. There is a $25 fee for all returned checks. Keep in mind that your insurance company policy is a contract between you and your insurance company. If your insurance company does not pay the practice within a reasonable amount of time, you will be responsible for these charges. Additionally your insurance plan may not cover all services. Please understand your individual policy benefits and limitations prior to your visits at our office. If your account is sent to a collection agency for non payment, additional collection agency fees will be added to your account.

Minor patients of divorced parents:
A divorce decree is a legal agreement binding only upon the two parties who made the agreement. Regardless of whom the judge deemed financially responsible for medical bills, THE PARENT WHO BRINGS THE CHILD TO THE OFFICE FOR MEDICAL TREATMENT IS RESPONSIBLE FOR PAYMENT AT THE TIME OF SERVICE. The parents can settle the financial responsibilities between themselves. Please do not ask us to do this for you.

Medical Home Philosophy and Preventive Health Care:
At Wilson Pediatrics, we provide complete medical care to infants, children and teens. We want you to include us in all important medical decisions. We will give you our honest medical opinion as to your options and best choices for medical care. In return we expect you to provide your complete medical history including information about care you have received outside Wilson Pediatrics. Well care is a necessary and mandatory part of our practice. Physical appointments are given more time than the “same day sick visits” and are the appropriate place to discuss any concerns you have about growth and development. We like to schedule these appointments close to your child’s birthday. Please check with your insurance company as some will not allow a physical every calendar year.

No Show Policy
We are proud of our "on time" performance. We never intentionally overbook appointments to cover potential "no show" appointments. It is your responsibility to show for your appointments on time. We will make every effort to confirm your appointments the day before you are scheduled as a courtesy; ultimately this is your responsibility. Repeated missed appointments will lead to dismissal from our practice. Please give us 24 hours notice to reschedule your appointments. Less than 24 hours notice will be considered a "no show."

Signature_____Date_____