

Pediatric Associates of Lewiston P.A.

33 Mollison Way, Lewiston, ME 04240

Patient Information Sheet

Date : _____

Child's Father

Last Name: _____ First Name: _____ MI: _____ Home Phone: _____

Street Address _____ Work Phone : _____

City: _____ State: _____ Date of Birth: _____

Zip Code: _____ Social Sec. #: _____

Employer/School _____ Marital Status: _____

Need Interpreter: yes _____ No: _____ Language spoken: _____

Child's Mother

Last Name: _____ First name: _____ MI _____ Home Phone: _____

Street Address : _____ Work Phone: _____

City : _____ State: _____ Zip code _____ Date of Birth: _____

Employer /School: _____ Social Sec. # _____

Marital status _____

Need Interpreter :Yes _____ No: _____ Language spoken: _____

Children Information

Full Name	Sex	Date of Birth	Social Sec. #	Insurance	PCP

Please note: children under 18 years of age will not be seen unless accompanied by a Parent or Guardian

Primary Pharmacy Used _____ **Phone #** _____

Insurance information (Primary)

Name of Insurance: _____

Street Address: _____

City, State, Zip: _____

Phone #: _____

Insurance Information (secondary)

Name of Insurance: _____

Street Address: _____

City, State, Zip: _____

Phone #: _____

Insurance ID# _____

Group name or # _____

Insurance ID# _____

Group name or # _____

- 1. I certify that to the best of my knowledge the above information is correct.**
- 2. I authorize Pediatric Associates of Lewiston P.A. to review my insurance coverage with my insurance company as indicated**
- 3. I authorize Pediatric Associates of Lewiston P.A. to release medical and other information to my insurance company for review of my coverage and/ or for the processing of claims for services rendered to me.**
- 4. I further authorize the release to Pediatric Associates of Lewiston, P.A of such information as may be necessary for the purpose by my insurance company.**
- 5. I permit a copy of this authorization to be used in place of the original.**
- 6. I hereby authorize you to pay directly to Pediatric Associates of Lewiston, P.A. benefits due me out of my indemnity under the terms of my policy issued by your company.**
- 7. The undersigned agrees that all services are rendered on a paid basis only. If collection becomes necessary, the undersigned shall pay all costs including attorney's fees.**
- 8. I authorize Pediatric Associates of Lewiston, P.A. to release copies of my medical records to other medical providers who I maybe referred to, to further my care.**

Signature: _____ **Date:** _____

Signature: _____ **Date:** _____

OVER



Pediatric Associates of Lewiston P.A.

33 Mollison Way * Lewiston, Maine 04240
Tel. (207) 784-5782 *Fax. (207) 783-9268

Financial Policy

Thank you for choosing us as the health care provider for your children. We are committed to the care and treatment of your children. Please understand that payment of your bill is considered a part of this treatment. The following is a statement of our Financial Policy which we require that you read and sign prior to any treatment .

All patients must complete our information and Insurance form.

FULL PAYMENT IS DUE AT TIME OF SERVICE.

WE ACCEPT CASH, CHECKS, AND

VISA/ MASTERCARD/DISCOVER/AMERICAN EXPRESS.

WE OFFER AN EXTENDED PAYMENT PLAN WITH PRIOR CREDIT APPROVAL.

Regarding Insurance

We may accept assignment of insurance benefits. However, your insurance requires that copayments be paid at time of service. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance unless you bring in all insurance information and an original claim form. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid your account in full within 60 days, the balance will be automatically transferred to you. Please be aware some and perhaps all of the services provided may be non-covered services and not considered reasonable and necessary by your insurance program, in this event, these services remain your responsibility.

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Minor Patients

The adult accompanying a minor and the parents (or guardians) are responsible for full payment.

Missed Appointments

Unless canceled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit. Please help us serve you better by keeping scheduled appointments .Thank you for understanding our Financial Policy.

Please let us know if you have any questions or concerns. I have read the Financial Policy. I understand and agree to this Financial Policy.

X _____ Date: _____
Signature of Patient or Responsible Party

X _____ Date: _____
Signature of Co-Responsible Party