

Oconee Pediatrics 15579 Wells Highway Seneca, SC 29678

Patient Information

Last name _____ First _____ Middle _____
SS# _____ DOB _____ Sex _____ Race _____

Siblings to patient:

Parent or Guardian Information

Last name _____ First _____ Middle _____ DOB _____
Address _____ City _____ State _____ Zip _____
SS# _____ Home Phone _____ Cell Phone _____

Parent or Guardian Employer

Employer _____ Phone _____
Address _____ City _____ State _____ Zip _____

Parent or Guardian Spouse Information

Last name _____ First _____ Middle _____ DOB _____
Address _____ City _____ State _____ Zip _____

Spouse's Employer Information

Employer _____ Phone _____
Address _____ City _____ State _____ Zip _____

Primary Insurance Information* please provide us with a copy of your current insurance card*

Insured's Name _____ DOB _____ Policy Number _____
Insurance Company Name _____ Phone _____

The following person (s) may bring my child in for medical treatment (please state relationship)

In case of emergency, please call (if I am not available)

Name _____ Home Phone _____ Cell Phone _____
Relationship to child _____

Assignment of Insurance and Release/Consent to Treat

Payment is expected at the time of service. Insurance is considered a method of reimbursing the patient for fees paid directly to the Provider and is not a substitute for payment. Some companies will pay fixed allowances for certain procedures and others pay a percentage of the charge. It is the parent's ultimate responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance company. If we are filing you claim, we will allow 30 days from the filing date for the carrier to process your claim and make payment accordingly. If payment from you insurance is not received within the time frame specified above, we will notify you by billing to take care of your balance. Billing is done as a courtesy to the patient and is not done as to dismiss patient's responsibility.

I certify that I have read and understand fully the providers billing policy, and agree to make payment in full and/or make satisfactory arrangements when asked to do so as specified above. I authorize Oconee Pediatrics to release any information to my insurance company to assist in the claims payment process.

I give consent for the providers of Oconee Pediatrics to diagnose and treat the patient in the above listed information.

Signature of Responsible Party _____ Date _____

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Financial Policy

It is our policy to provide excellent quality health care to our patients and to run our practice efficiently. By collecting at the time of service, we are able to offer the highest quality healthcare at affordable pricing. We sincerely appreciate your understanding in this matter.

Medicaid-all Medicaid recipients must present their current card at the time of service. If the card is unavailable and the Medicaid is not currently active, the visit may be rescheduled or you may pay for the visit at the time of service. We currently participate with South Carolina Solutions and First Choice.

Private Insurance and Self Pay- *Payment is expected at the time of service.* This includes the amount in full should your deductible not be met, co-insurance if your deductible is met and or co-pays that are required by your insurance plan. We accept cash, checks, debit cards, and most major credit cards. Any other payment arrangements must be made *prior* to the office visit.

Other important information:

- . Any check returned to our office for non-payment will generate an additional processing fee of \$25.00.
- . Visits that are not cancelled at least 24 hours prior to the appointment time may result in a Missed Appointment. Three missed appointments may result in discharge from the practice.
- . Any account that accumulates an unpaid debt that exceeds 60 days with no payment and no effort on the part of the client to pay on the debt will begin in a collections process. Forty five days from the start of the collections process an account will be discharged from the practice for non-payment if no payment or activity has occurred on the account during that time.
- . Please help us by being prepared with all insurance and payment information at every office visit.
- . It is the patient’s responsibility to provide our office with up to date, insurance, address and telephone information.
- . For any questions or concerns regarding an outstanding balance please call and speak with the insurance manager or office manager. We will be happy to assist you!

*******IMPORTANT-PLEASE COMPLETE*******

PHONE MESSAGES MAY BE LEFT WITH ANYONE WHO ANSWERS THE PHONE AT ANY OF THE LISTED CONTACT NUMBERS AND/OR ON ANY ANSWERING MACHINE OF THE LISTED CONTACT NUMBERS.

YES _____ NO _____

IF YOU ANSWERED NO, PLEASE ADVISE US ON HOW WE MAY BEST CONTACT YOU FOR APPOINTMENT CHANGES, ACCOUNT RELATED MATTERS, AND/OR ANY HEALTH MATTERS.

I have read and understand the above stated policies:

Patient’s Name _____

Print Responsible Party’s Name _____

Responsible Party’s Signature _____ Date: _____