

# Spring Grove Family Care Center

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## Patient Information Child Registration

\_\_\_\_\_  
Name-Last, First, Middle      Birthdate      Social Security #

\_\_\_\_\_  
Street Address      Cell Phone

\_\_\_\_\_  
City      State      Zip Code      Home Phone

\_\_\_\_\_  
Mother/Guardian      Address/Phone (if different from child)

\_\_\_\_\_  
Social Security #      Date of Birth      Employer/Phone #

\_\_\_\_\_  
Father's Name      Address/Phone (if different from child)

\_\_\_\_\_  
Social Security #      Date of Birth      Employer/Phone #

## Payment Information

\_\_\_\_\_  
Responsible Party Name      Birthdate      Social Security #      Phone

\_\_\_\_\_  
Employer Name      Employer Address

\_\_\_\_\_  
Primary Insurance      Secondary Insurance

## Authorization

I consent to treatment as necessary or desirable to the care of the patient, including but not restricted to whatever drugs, medicine, surgical procedures and diagnostic testing including laboratory, x-ray, or other studies that may be used by the attending physician, or qualified designate. I authorize the physician, designate, or practice to release pertinent information regarding my medical care, services, and treatment to the Centers for Medicare Services and/or my current insurance carrier and their agents for the purpose of determining the benefits payable for these and/or related services. I request that the payment of authorized Medicare and/or Insurance benefits be made on my behalf to the aforementioned provider/practice. I understand that I am responsible for all fees regardless of insurance coverage.

\_\_\_\_\_  
Signature of Parent/Guardian      Date

## **Our Financial Policy**

Thank you for choosing us as your healthcare provider. We are committed to the success of your treatment. Please understand that payment of your bill is considered a part of the treatment process. The following is a statement of our “Financial Policy” which we require that you read and sign prior to our rendering any service or treatment is rendered.

**Payment in full is due at the time of service unless prior arrangements are made.**

**We accept Cash, Check, Visa, Master Card or Money Order.**

**Patients who have no insurance and are paying for their visit in Full Will Receive A 20% Discount At Checkout.**

### **Insurance Participation**

We may accept assignment of benefits from designated insurance carriers. However, we do require that the estimated co-payments and Deductibles be paid at the time of service. The balance is **your** responsibility whether your insurance pays or not. We cannot bill your insurance company unless you provide current and accurate insurance information. Our office will require copies of the front and back of our insurance Cards.

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract unless you are insured by a plan with which we participate and have signed an agreement. If your insurance company has not paid your account in full within 60 days, the balance due will be automatically transferred to your account. Please be aware that some, and perhaps all of the services provided to you may be considered non-covered or not reasonable and necessary under the policies of your medical insurance carrier or Medicare. In the event that your insurance coverage changes to a plan with which we do not participate, we will require assignment of benefits to our office or full payment will be due according to the payment arrangements.

### **Adult Patients**

Adult patients are responsible to adhere to the above policy which may require full payment at time of service.

### **Minor Patients**

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

### **Missed Appointments**

Please help us serve you better by keeping scheduled appointments. Unless cancelled, at least 24 hours in advance, our policy is to charge for the missed appointment.

Thank you in advance for your understanding of our Financial Policy. Please let us know if you have any questions or concerns.

I have read and understand the “Financial Policy” and agree to abide with the requirements.

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Signature of Patient or Responsible Party

Date