Alabama Pediatrics

2815 Independence Drive Birmingham, Alabama 35209 Account Number _____

PATIENT INFORMATION **DOB**

FIRST NAME	M.I.	LAST NAME	MALE	FEMALE	MONTH	DAY	YEAR
			✔	✔			

ADDRESS	CITY	STATE	ZIP	HOME PHONE #

Responsible Guarantor (Must match signature at bottom of form) **DOB**

FIRST NAME	M.I.	LAST NAME	SOCIAL SECURITY #	MONTH	DAY	YEAR

EMPLOYER	WORK PHONE #	CELL PHONE #	E-MAIL ADDRESS

Secondary Guarantor (Check one) Mother ✓ / Father ✓ **DOB**

FIRST NAME	M.I.	LAST NAME	SOCIAL SECURITY #	MONTH	DAY	YEAR

HOME ADDRESS *(If Different from primary guarantor)*	CITY	STATE	ZIP

EMPLOYER	WORK PHONE #	CELL PHONE#	E-MAIL ADDRESS

EMERGENCY CONTACT (OTHER THAN ABOVE)

NAME	RELATIONSHIP	HOME PHONE #	CELL PHONE#

PRIMARY INSURANCE COMPANY

INSURANCE COMPANY NAME		
NAME OF INSURED AS IT APPEARS ON INSURANCE CARD		
POLICY NUMBER	EFFECTIVE DATE / /	
RELATIONSHIP TO PATIENT	*DOB* MONTH DAY YEAR / /	

SECONDARY INSURANCE COMPANY

INSURANCE COMPANY NAME	
NAME OF INSURED AS IT APPEARS ON INSURANCE CARD	
POLICY NUMBER	EFFECTIVE DATE / /
RELATIONSHIP TO PATIENT	DOB MONTH DAY YEAR / /

Name and Birth Date of Siblings _____ _____

_____ _____ _____

EXPLANATION OF NON-COVERED ROUTINE SERVICE POLICY AUTHORIZATION RELEASE AND PAYMENT POLICY

As Pediatricians we want to provide the best care possible. ****There may be certain routine services that we feel are necessary for the maintenance of good health that are not covered by your insurance contract(s). You will be expected to pay for these services in full. For Example: Routine vision and hearing screens and some recommended health checks may not be covered by your contract(s). Other tests may not be covered depending on your particular insurance policy(s).**

Our recommendations for Health Supervision follow the guidelines of the American Academy of Pediatrics. We will only order tests that we feel are necessary for the overall health of your child.

****We ask that you pay for services rendered and Co-Pays at the time of service** to reduce billing and bookkeeping costs and reduce overall costs to our patients.

I, the parent of guardian of the above child, do hereby authorize **Alabama Pediatrics** and all of its physicians to give this child any treatment or immunization(s) that such physicians deem necessary for his/her health.

I acknowledge the release of medical information on this child to any physician or insurance carrier.

*******I acknowledge that I am totally responsible for all charges for services rendered to this child including services under the Non-Covered Routine Service Policy above. I, the undersigned, will be responsible to pay all costs of collections including reasonable interest, reasonable attorney fees and reasonable collection agency fees not to exceed 40 %.***

Signature of Responsible Party _____ **Date** / /_____