ACCOUNT #: _____

Alabama Pediatrics

2815 Independence Drive, Birmingham, Alabama 35209

PATIENT INFORMATION

FIRST NAME	MIDDLE NAME	LAST NAME	GENDER (CIRCLE ONE) MALE FEMALE	DATE OF BIRTH

HOME ADDRESS	CITY	STATE	ZIP	CELL PHONE #

Race:

Mother/Father/Guardian (CIRCLE) : Responsible Guarantor (This is the person signing below.)

FIRST NAME	MIDDLE NAME	LAST NAME	SOCIAL SECURITY #	DATE OF BIRTH

EMPLOYER	CELL PHONE #	SECOND PHONE #	E-MAIL ADDRESS

Mother/Father/Guardian (CIRCLE): Secondary Guarantor (other parent)

FIRST NAME	MIDDLE NAME	LAST NAME	SOCIAL SECURITY #	DATE OF BIRTH

HOME ADDRESS *(IF SAME ADDRESS, CHECK BOX)* ☐	CITY	STATE	ZIP

EMPLOYER	CELL PHONE #	SECOND PHONE#	E-MAIL ADDRESS

EMERGENCY CONTACT (OTHER THAN ABOVE)

NAME	RELATIONSHIP	CELL PHONE #	ADDRESS

PRIMARY INSURANCE COMPANY	*SECONDARY INSURANCE COMPANY*
NAME	NAME
NAME OF INSURED AS IT APPEARS ON INSURANCE CARD	NAME OF INSURED AS IT APPEARS ON INSURANCE CARD
POLICY NUMBER CO-PAY	POLICY NUMBER CO-PAY
EFFECTIVE DATE RELATIONSHIP TO PATIENT	EFFECTIVE DATE RELATIONSHIP TO PATIENT

Name and Birth Date of Siblings _____ _____

_____ _____

BUSINESS OFFICE, PATIENT CARE AND PAYMENT POLICIES

Patient care in our office follows 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.. ****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 within 30 days of the service date. It is the guarantor's responsibility to understand their child's specific health insurance coverage and to provide all accurate and updated information to their child's insurance company.** I, the parent or 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. THIS AGREEMENT ALSO APPLIES TO PATIENTS OVER 18 years of age who are the guarantors of their own accounts. *****I acknowledge that I am responsible for all charges for services rendered to this child including services not covered by my child's insurance coverage.. 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 %.*** I understand that detailed business office policies and practice policies for Alabama Pediatrics may be reviewed at https://alaped.com. Policies and fees may change without prior notification.

Signature of Responsible Party _____ **Date** _____