

Darien Pediatric Associates, LLC

106 Noroton Ave, Darien, CT, 06820
Phone: (203) 655-9741 – Fax: (203) 655-9249

*** CURRENT INFORMATION SHEETS ARE REQUIRED YEARLY BY YOUR INSURANCE COMPANY ***											
CHILD(REN)'S INFORMATION											
NAMES SHOULD BE EXACTLY AS PRINTED ON INSURANCE CARD											
Name: (First) (MI) (Last)			Cell Phone:		Date of Birth:		Gender:		Insurance ID #:		
Name: (First) (MI) (Last)			Cell Phone:		Date of Birth:		Gender:		Insurance ID #:		
Name: (First) (MI) (Last)			Cell Phone:		Date of Birth:		Gender:		Insurance ID #:		
Name: (First) (MI) (Last)			Cell Phone:		Date of Birth:		Gender:		Insurance ID #:		
Name: (First) (MI) (Last)			Cell Phone:		Date of Birth:		Gender:		Insurance ID #:		
PARENT INFORMATION											
Name: (First) (MI) (Last)					Date of Birth:		Marital Status:		Social Security #:		
Address:					City:			State:		Zip:	
Home Phone:		Work Phone:		Cell Phone:		E-mail:			Employer/Occupation:		
PARENT INFORMATION											
Name: (First) (MI) (Last)					Date of Birth:		Marital Status:		Social Security #:		
Address:					City:			State:		Zip:	
Home Phone:		Work Phone:		Cell Phone:		E-mail:			Employer/Occupation:		
EMERGENCY CONTACT INFORMATION – (SOMEONE OTHER THAN PARENTS)											
Name: (First) (MI) (Last)							Relationship To Child:				
Home Phone:				Work Phone:			Cell Phone:				
INSURANCE INFORMATION											
CARRIER OF INSURANCE: <input type="checkbox"/> MOTHER <input type="checkbox"/> FATHER <input type="checkbox"/> OTHER (IF OTHER, PLEASE FILL IN BELOW)											
Insurance Company Name:					Identification # / Group #:			Effective Start Date:			
Subscriber Name:				Subscriber SS#:		Subscriber Date of Birth:		Relationship To Child:			
Is this a deductible plan? Yes No				What is the deductible?							

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Darien Pediatric Associates, LLC

FINANCIAL POLICY

Darien Pediatric Associates, LLC participates in many insurance plans and even within the same insurance company there are many versions of coverage. It is YOUR responsibility to fully understand your plan and any health savings accounts you may have. According to YOUR insurance plan, **you are responsible for any and all co-payments, deductibles and co-insurances at the time of your visit.** ***You may settle your account at check out on the day of service by check, cash or credit card. Insurance cards must be presented at each visit.***

There will be a \$10.00 surcharge for any co-payment that is not received at the time of service.

All consults and physical exam appointments require a 24 hour minimum cancellation notice during normal business hours, to avoid a cancellation fee of \$50. Please be advised messages left with the answering service on Sundays, will be subject to cancellation fees. Husky patients may be discharged for no-shows, as government rules prohibit this fee.

Please note, after normal business hours, most insurers recognize after hour codes and we charge for these. Urgent care centers and ERs have significantly higher co-pays and deductibles. If your insurer does not cover these after hour codes, you will be responsible.

If your insurance plan requires that a referral be processed through its system for a visit with a specialist, we require 72 hours prior notice to process that referral; referrals that are done on the same day will incur a fee of \$25 which will be applied to your account.

Physical examination appointments will be not booked if there is an outstanding/past due balance on the account.

Unfortunately, some of our families become involved in divorces. We do our best to provide whatever support we can for the child and the family. First and foremost, however, we are the child's advocate and will not become involved in disputes between parents except where we believe the child's welfare is at stake. **Divorce does not eliminate the parents' financial responsibility for a child's medical care. It is our policy that the parent or person bringing the child to our office is responsible to pay for medical care. It is the parents' sole responsibility to settle these financial matters between themselves.**

We realize some families from time to time experience financial difficulties and we want to always be here to care for your children. Communicating any hardships with us ensures uninterrupted medical care. It is of the utmost importance to discuss these issues and make financial arrangements with our billing office. However, if you ignore or fail to respond to your financial obligation, we will have no choice but to enforce our non-payment policy, which follows:

Any accounts over 45 days will receive a certified letter and must be settled in 7 business days. If payment is not received or arrangements made, we will assume you no longer want to have your children seen at Darien Pediatric Associates, LLC. Your account will be sent to collection and all legal fees and collection expenses will be added to your balance. By law, we will continue to provide emergency care for 30 days from date of notice. Should a patient need non-emergent medical attention in those 30 days, you will be required to settle your account prior to the visit.

I authorize Darien Pediatric Associates, LLC, to treat my child/children and the release of medical information as necessary for the completion of insurance, school and camp forms. I authorize payment directly to Darien Pediatric Associates, LLC, for any and all medical benefits payable to me under the terms of my insurance. I understand that I am financially responsible for all charges whether or not paid by said insurance. I understand that I am financially responsible for all co-payments, deductibles and any charges not covered under my insurance benefits. I also understand I am responsible for advising Darien Pediatric Associates, LLC, of any changes to my insurance. If I do not have insurance coverage, I understand I am responsible for payment in full. This assignment will remain in effect until revoked in writing.

Signed (Adult Responsible for Payment):

Print Name:

Date: