

# Pediatric, Adolescent Surgical Associates, P.C.

Patient Number

Suite 570      5455 Meridian Mark Road      Atlanta, GA 30342      (404) 252-3353      FAX 404 252-0645

Child / Patient Legal Name \_\_\_\_\_  
 First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_ Nickname \_\_\_\_\_

Date of Birth \_\_\_\_\_ Sex M  F  Patient's SS # \_\_\_\_\_  
 month \_\_\_\_\_ day \_\_\_\_\_ year \_\_\_\_\_

Address \_\_\_\_\_ Race \_\_\_\_\_ Marital Status \_\_\_\_\_  
 Street \_\_\_\_\_ Apt # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone (\_\_\_\_\_) \_\_\_\_\_

Father's Name \_\_\_\_\_ SS # \_\_\_\_\_

Date of Birth \_\_\_\_\_ Occupation \_\_\_\_\_  
 month \_\_\_\_\_ day \_\_\_\_\_ year \_\_\_\_\_

Address (if different from patient) \_\_\_\_\_  
 Home Phone (if different from patient) (\_\_\_\_\_) \_\_\_\_\_ Cell # (\_\_\_\_\_) \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone # (\_\_\_\_\_) \_\_\_\_\_

Mother's Name \_\_\_\_\_ SS # \_\_\_\_\_

Date of Birth \_\_\_\_\_ Occupation \_\_\_\_\_  
 month \_\_\_\_\_ day \_\_\_\_\_ year \_\_\_\_\_

Address (if different from patient) \_\_\_\_\_  
 Home Phone (if different from patient) (\_\_\_\_\_) \_\_\_\_\_ Cell # (\_\_\_\_\_) \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone # (\_\_\_\_\_) \_\_\_\_\_

Person responsible for payment? \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Address (if different from patient) \_\_\_\_\_  
 Telephone # (\_\_\_\_\_) \_\_\_\_\_

Emergency Contact Other Than Parent \_\_\_\_\_

Address \_\_\_\_\_  
 Telephone # (\_\_\_\_\_) \_\_\_\_\_

**REFERRING PHYSICIAN**

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone # \_\_\_\_\_ Fax # \_\_\_\_\_

**PRIMARY CARE PHYSICIAN**  
*IF DIFFERENT THAN REFERRING PHYSICIAN*

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone # \_\_\_\_\_ Fax # \_\_\_\_\_

I attest that the above information is true and correct regarding my child (or another person for whom I have authority to sign).

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

Parent/Guardian Print Name \_\_\_\_\_ Witness Initials \_\_\_\_\_

PATIENT NAME \_\_\_\_\_ PATIENT # \_\_\_\_\_

**PEDIATRIC, ADOLESCENT SURGICAL ASSOCIATES, P.C.**  
**Assignment of Insurance Benefits – Financial and Payment Policies**

**INSURANCE INFORMATION**

**PRIMARY INSURANCE** Name \_\_\_\_\_  
Mailing Address \_\_\_\_\_  
Telephone # (\_\_\_\_\_) \_\_\_\_\_  
Policy Holder's name \_\_\_\_\_ Effective Date \_\_\_\_\_  
ID Number \_\_\_\_\_ Group # \_\_\_\_\_

**SECONDARY INSURANCE** Name \_\_\_\_\_  
Mailing Address \_\_\_\_\_  
Telephone # (\_\_\_\_\_) \_\_\_\_\_  
Policy Holder's name \_\_\_\_\_ Effective Date \_\_\_\_\_  
ID Number \_\_\_\_\_ Group # \_\_\_\_\_

I hereby assign payment of medical benefits to Pediatric, Adolescent Surgical Associates, P.C. for medical treatment rendered to my child (or another person for whom you have the authority to sign). I understand that payment for medical services rendered is expected at the time of service if I do not have proof of medical coverage or if Pediatric, Adolescent Surgical Associates, P.C. is not a contracted provider for my insurance company.

**FINANCIAL POLICY**

In order to accommodate the needs and request of our patients, we have enrolled in numerous insurance programs. However, due to the continually changing insurance industry, we are not a member of all insurance plans. Therefore, **it is the responsibility of the parent / insured to confirm the Physician's participation with a particular insurance plan**, as well as to know if or when referrals are required to see one of our Doctors.

**REFERRALS**

If you participate in an insurance plan that required you to have a referral for your child's visit, you must coordinate getting that referral through your primary care physician prior to your child's appointment. You are responsible for making certain the referral is in our office prior to your visit. Patients without valid referrals will be rescheduled or will be responsible for payment at the time of service.

**INSURANCE CONTRACT REQUIREMENTS**

By contract, all co-pays and / or co-insurance must be paid at the time of your child's visit. If your yearly deductible has not been met, a portion of this may be required at the time of your child's visit.

**SELF PAY**

If you do not have insurance or have insurance in which we participate, payment is expected at the time of service. For your convenience, we accept cash, check, Visa, MasterCard, Discover and American Express.

**Custody and maintenance issues are not our responsibility to define or enforce. We expect payment from the individual signing below as the responsible party for this patient.**

**FINANCIAL RESPONSIBILITY**

If I choose to utilize out of network benefits, provide incorrect or incomplete insurance information or do not follow the guidelines as stated by my insurance company, I will be held responsible for any and all charges. As a courtesy, Pediatric, Adolescent Surgical Associates, P.C. will file an insurance claim when possible, but may still need my assistance to collect payment from my insurance carrier. I understand that my medical coverage is a contract between me and my medical insurance provider. If payment is not made from my medical insurance provider, I understand that I will be held responsible for any and all unpaid charges.

\_\_\_\_\_  
Signature of Parent or Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Parent or Legal Guardian

\_\_\_\_\_  
Witness Signature

