



Patient Information

Patient Number

Pediatric Adolescent Surgical Associates, P.C. 5455 Meridian Mark Road . Suite 570 Atlanta . GA 30342

404.252.3353 FAX 404.252.0645

Child/Patient's Legal Name _____ Preferred Name _____
 First _____ Middle _____ Last _____
 Date of Birth _____ Sex M F Patient's SS# _____
 Month _____ Day _____ Year _____ Sex check one
 Home Address _____ Race _____ Marital Status Married Single
 Street _____ Apt # _____
 City _____ State _____ Zip Code _____ Home Phone _____ - _____ - _____

Father's Name _____ Date of Birth _____ Father's SS# _____
 Month _____ Day _____ Year _____
 Address _____ Home Phone _____ - _____ - _____
 (if different from patient) Street _____ Apt # _____
 City _____ State _____ Zip Code _____ Celluar Phone _____ - _____ - _____
 Employer _____ Occupation _____ Work Phone _____ - _____ - _____

Mother's Name _____ Date of Birth _____ Mother's SS# _____
 Month _____ Day _____ Year _____
 Address _____ Home Phone _____ - _____ - _____
 (if different from patient) Street _____ Apt # _____
 City _____ State _____ Zip Code _____ Celluar Phone _____ - _____ - _____
 Employer _____ Occupation _____ Work Phone _____ - _____ - _____

Person responsible for payment? _____ Relationship to Patient _____ Home Phone _____ - _____ - _____
 Address _____ Celluar Phone _____ - _____ - _____
 (if different from patient) Street _____ Apt # _____
 City _____ State _____ Zip Code _____ Work Phone _____ - _____ - _____

Emergency Contact _____ Relationship to Patient _____ Home Phone _____ - _____ - _____
 (other than parent) _____
 Address _____ Celluar Phone _____ - _____ - _____
 Street _____ Apt # _____
 City _____ State _____ Zip Code _____ Work Phone _____ - _____ - _____

REFERRING PHYSICIAN

Name _____ Phone _____ - _____ - _____ Fax _____ - _____ - _____
 Address _____
 Street _____ Suite # _____ City _____ State _____ Zip Code _____

PRIMARY CARE PHYSICIAN IF DIFFERENT FROM REFERRING PHYSICIAN

Name _____ Phone _____ - _____ - _____ Fax _____ - _____ - _____
 Address _____
 Street _____ Suite # _____ City _____ State _____ Zip Code _____

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 _____ Month _____ Day _____ Year _____
 Parent/Guardian Print Name _____ Witness Initials _____



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Assignment of Insurance Benefits – Financial and Payment Policies

Insurance Information

PRIMARY INSURANCE

Company Name _____ Phone _____ - _____ - _____

Address _____
Street Suite City State Zip Code

POLICY HOLDER

Name _____ Effective Date _____ - _____ - _____

ID # _____ Group # _____

SECONDARY INSURANCE

Company Name _____ Phone _____ - _____ - _____

Address _____
Street Suite City State Zip Code

POLICY HOLDER

Name _____ Effective Date _____ - _____ - _____

ID # _____ 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 requires 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 do not participate or are not contracted with, 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.

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 _____
Print Name

Parent/Guardian
Signature _____ Date _____
Month Day Year Witness Signature _____

