CASTLE ROCK PEDIATRICS

PATIENT INSURANCE INFORMATION

Please complete fully and provide a copy of each child's insurance card.
Cash pay patients please list CASH as the Insurance Co.

PATIENT NAME(S) _____

PRIMARY INSURANCE		
ADDRESS	CITY, ZIP	
POLICY #	GROUP #	EFFECTIVE DATE
NAME OF PRIMARY INSURED	DATE OF BIRTH	PHONE
ADDRESS		CITY, ZIP

(Please fill out the address information only if the primary insured is not listed on the Patient Demographics form.)

SECONDARY INSURANCE		
ADDRESS	CITY, ZIP	
POLICY #	GROUP #	EFFECTIVE DATE
NAME OF PRIMARY INSURED	DATE OF BIRTH	PHONE
ADDRESS		CITY, ZIP

(Please fill out the address information only if the primary insured is not listed on the Patient Demographics form.)

PREFERRED PHARMACY and LOCATION

There is a $10.00 charge for co-pays not paid at the time of service.

Uninsured patients must pay in full at time of service. We are contracted with selected insurance companies, as a courtesy to our patients, we will bill your ***primary*** insurance company for services provided. Complete insurance information, including all insurance identification cards, must be made available to our office. Benefits denied by the insurance company are the responsibility of the parent unless otherwise determined by contract agreement with the insurance company. If Castle Rock Pediatrics or one of our physicians is not listed as "PCP" with your insurance company on the date of service the parent assumes full financial responsibility for all unpaid or denied charges. Accounts balances over 90 days past due are subject to a 20% APR monthly compounded interest charge. Should it become necessary to turn accounts over to a collection agency, the parent acknowledges that the parent is responsible for any fees and interest associated with unpaid account balances.

By this agreement, I also authorize treatment and the exchange of Protected Health Information (via writing, phone, Email, or postcard, etc.) relating to my child's care with any organization involved in my child's treatment, payment of services received or healthcare organization, and authorize insurance payment to be made directly to Castle Rock Pediatrics for the medical and/or surgical care provided under my insurance agreement and otherwise payable to me.

Patient/Parent Guarantor Agreement:
I have read and understand the policy above and agree to the terms stated:

_____ _____ _____

PARENT/LEGAL GUARDIAN'S SIGNATURE | PARENT/LEGAL GUARDIAN'S PRINTED NAME | DATE