Northpointe Pediatrics, P.C.

Patient Information

Today's Date _____

Please Print Clearly and Complete Form

First Name		Last Name	
Sex (circle one)	Male / Female	Nickname	
Date of Birth		Phone	
Email*			

*For patient portal, must activate password within 24-48 hours once you receive correspondence from Eclinical

Do you allow Northpointe Pediatrics to view prescriptions given to your child from other pharmacies? Yes/No

*****Race (check all that applies)**

- African American/Black
- Caucasian/White
- Asian
- Native Hawaiian/Other Pacific Islander
- Refuse to respond

***** Ethnicity (check one only)**

- Hispanic/Latino
- Non Hispanic/Non Latino
- Refuse to respond

Father's Name		Father's DOB	
Address		City and Zip	
Phone#		SS#	
Occupation		Employer	
Mother's Name		Mother's DOB	
Address		City and Zip	
Phone#		SS#	
Occupation		Employer	

Policy Holder Information

Name (First, Last)		SS#	
DOB		Relation to Patient	
Work Phone#			
Primary Language Spoken in the home			
Translator needed? (please circle one)		Yes / No	

Emergency Contact Information (other than parents)

Name		Phone #	
Relation to child			
Person(s) to seek care for child besides parents :			

(continued on back)

Northpointe Pediatrics, P.C.
FINANCIAL POLICY

We are committed to providing your child/children with the best possible care. If you have insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

Payments, including co-pays, are due at the time services are rendered, unless payment arrangements have been approved by our billing department. There will be a $5.00 charge added to your account for billing costs if payment is not made at the time of service. We accept cash, check, MC, Visa, Discover and American Express cards. Returned checks and balances older than 30 days will be subject to additional fees.

While filing of participating insurance claims is a courtesy that we extend to all of our patients, all charges are ultimately your responsibility on the day services are rendered. Please be aware that insurance companies arbitrarily select certain services they will not cover under your insurance plan. We emphasize then, as health care providers, our relationship is with YOU, and not your insurance company.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact our billing department promptly for assistance in management of your account. All past due accounts, over 90 days, will be handled by Congress Collection Agency. If you have any questions or concerns pertaining to our financial policy, please do not hesitate to ask us. We are here to help you.

Release- Assignment- Acknowledgement

All information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I understand and agree to the terms of the above financial policy.

I certify that my child/children are covered by insurance with _____
And assign directly to NORTHPOINTE PEDIATRICS, PC all inurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits.

I authorize the use of this signature on all my insurance submissions whether manual or electronic. I acknowledge receipt of Northpointe Pediatrics, PC "Notice of Privacy Practices" effective January, 2008.

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Signature of Parent of Guardian **Date**