BERGEN WEST PEDIATRIC CENTER, P.A. INSURANCE/DEMOGRAPHIC INFORMATION FORM

Patient's Last Name: ________________________ First Name/DOB: ____________________ M/F

Sibling's Name(s) & Birthdate(s):

1.______________________________________ 2.________________________________M/F

3.______________________________________ 4.________________________________M/F

5.______________________________________ 6.________________________________M/F

Street Address: ____

City/Town____State:_________Zip:_________

Home Phone: ____

Mother: ________________________________ Father: ________________________________

Natural Adoptive Step-Parent Legal Guardian Natural Adoptive Step-Parent Legal Guardian

Home Phone: ____________________________ Home Phone: ____________________________

Cell Phone: ______________________________ Cell Phone: ______________________________

Email: __________________________________ Email: __________________________________

Street Address: ___________________________ Street Address: ___________________________

City_________________ State_____ Zip _______ City_________________ State_____ Zip ________

Occupation:_______________________________ Occupation:_______________________________

Name of Employer: ________________________ Name of Employer: ________________________

Business Phone: ___________________________ Business Phone: ___________________________

Please list any additional guardians, step-parents, etc. on reverse side. Remember to sign consent form if you give permission for any non-legal guardians to have access to the patient's medical information.

INSURANCE INFORMATION

Insurance Co. and Plan Type____

Address: ____Phone:________________________

Subscriber Name: _______________________________________Relation to Patient________________

DOB: ____ Social Security #:________________________

ID Number: _____________________________________ Group #:______________________________

Secondary Insurance Co. and Plan Type: ____

Address: ____Phone:________________________

Subscriber Name: _______________________________________ Relation to Patient________________

DOB: ____ Social Security #:________________________

ID Number: _____________________________________ Group #:______________________________

Preferred Pharmacy/Address: ____

How did you hear about us? ____

Check box and initial if we may leave voice messages on your answering machine or voicemail ☐____________

Initials

Please indicate if you would prefer to receive appointment confirmations by: PHONE or EMAIL

I hereby fully authorize Bergen West Pediatric Center, P.A. and/or their agent to bill, receive, release, and exchange information with my insurance carrier.

Patient or parent/legal guardian signature: _________________________________Date: _____________

Print patient or parent/legal guardian name:

BERGEN WEST PEDIATRIC CENTER, P.A.
541 Cedar Hill Avenue, Wyckoff, NJ 07481
Ph: 201-652-0300 Fax: 201-444-6209

FINANCIAL POLICY

This form was created to help our patients understand what is expected of them regarding financial arrangements for medical care. If you have any questions concerning these policies please feel free to ask.

1. Patients are expected to pay their co-payments at the time of service. If you are unable to make payment, a $20.00 bill fee will be charged to your account. Patients who do not have valid insurance at the time of visit are responsible for payment in full.
2. Patients need to be aware of what type of insurance coverage they have. (e.g: physicians, facilities, hospitals, labs, etc) in your plan. Any precertification or predetermine letter we send to your insurance does not guarantee payment of services provided.
3. We will submit all claims to your insurance company are due within 90 days.
   - Patients who cannot present a valid insurance card at time of visit will be required to pay in full at time of service.
   - In the event a procedure is not a covered item with your insurance, we have the right to bill you separately for those charges.
4. There will be a No Show charge of $25.00 for any physical (well care) appointment that is NOT cancelled within 24 hours of the scheduled appointment.
5. For all return checks, there will be an additional charge of $25.00 added to your account.
6. Any medical forms to be completed by the doctor will require a $10.00 fee per form.
7. Copy of your medical records has a $20.00 charge. If records have been archived, there will be a $35.00 charge to retrieve them.
8. Forms requiring completion within 24 hours will incur a rush charge of $15.00 per form.
9. The responsibility for payment of services rendered to any dependent child, whose parents are divorced, rests with the parent who seeks treatment. Any court ordered responsibility judgment must be determined between the individuals involved without the inclusion of this office.
10. You authorize and guarantee payment for all services rendered. All balances are due within 30 days from statement date. In the event that the account becomes delinquent for more than 30 days, you agree to pay interest on any balance due, as well as all collections costs not to exceed 50%, court costs, attorney fees and interest fees accrued with the collection of this amount.

________________________________ ____________________

Signature of Patient/Parent or Legal Guardian Date

____

Child/Children Name (please print)

BERGEN WEST PEDIATRIC CENTER, PA

541 Cedar Hill Avenue, Wyckoff, NJ 07481
Ph: 201-652-0300 Fax: 201-444-6209

Patient: **Date:**
DOB: **Account #:**

HIPAA Patient Consent

This consent describes how our practice will use and disclose protected health information (PHI) about you to carry out treatment, payment and health care options. You have the right to review the Notice of Privacy Practices prior to signing this consent form. Our practice reserves the right to revise its Notice of Privacy Practices at any time.

By signing this form, I am giving consent for this practice to use and disclose my protected health information (PHI) to carry out treatment, payment and healthcare operations. I may revoke consent, in writing, except to the extent that the practice has already made disclosures in reliance upon my prior consent**.**

Signature of Patient, Parent or Legal Guardian ______________________________

Insurance Release

I hereby authorize and direct the above named practice, having treated me, to release governmental agencies, insurance carriers, or others who are financially liable for my medical care, all information needed to substantiate payment for such medical care and permit a representative to examine and make copies of all records relating to such treatment. Upon request for release of records, I hereby authorized the above named practice to furnish all records and results to the parties I specify. I hereby assign transfer and set over the above named practice sufficient monies and/or benefits to which I may be entitled from government agencies, insurance carriers, or others who are financially liable for my medical cost of care and treatment rendered to myself or my dependent in said practice. I understand I am responsible for any and all services not covered by my insurance company: such as co-pays, co-insurance, deductibles, etc.

If your insurance company requires a referral from your primary doctor, it is your responsibility to bring a valid referral at the time of your visit. Your insurance plan may not cover every service in this office. I t is your responsibility to understand the limits of your insurance coverage. We are not your insurance company and cannot be held responsible for explaining the details of your insurance since all insurance policies are not the same.

Signature of Patient, Parent or Legal Guardian ______________________________