Patient Information/Demographics

Last Name: _____ First name: _____ M.I_____

D.O.B:_____ Gender: M ( ) F ( ) SSN: _____

Street Address: _____ Apt/bldg.:_____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____

Primary Parent/Guardian Insurance Information

Primary Insurance Plan: _____ Insurance ID#: _____

Group #: _____ Policy Holder: _____

Policy Holder D.O.B:_____ Policy Holder SSN #:_____

Patient Relationship to Policy Holder: _____

Secondary Parent/Guardian Insurance Information (if applicable)

Primary Insurance Plan: _____ Insurance ID#: _____

Group #: _____ Policy Holder: _____

Policy Holder D.O.B:_____ Policy Holder SSN #:_____

Patient Relationship to Policy Holder: _____

Emergency Contact/Next of Kin

Name: _____ Telephone #:_____

Relationship to Patent: _____ D.O.B:_____

Medical Authorization: The undersigned permits TENNEY PEDIATRICS, who in providing care for my child, to examine, recommend/ use treatments, & explain associated risk involved. The undersigned also understands care may include diagnostic testing, exams, or surgical treatment & no guarantees have been made regarding the outcome of these treatments. In the event of my absence, I authorize TENNEY PEDIATRICS to provide necessary treatment to my child.

Financial Agreement: I have read, understand, and agree to comply with the TENNEY PEDIATRIC financial policy. The undersigned agrees to bear responsibility for verified account balances for treatment. Co-Pays are due at the time of service. I understand that although an claim will be filed with my insurance company on my behalf, any non-covered balance is my obligation. I agree to assign insurance benefits relating to care to TENNEY PEDIATRICS. If I have no active insurance, I understand that payments must be made at the time of service, unless prior arrangement has been made with TENNEY PEDIATRICS.

I understand that TENNEY PEDIATRICS may need to contact me regarding their family's healthcare, and it is very important to have correct contact information on file. I verify the above information is correct.

_____ _____

Parent/ Guardian/ Responsible Party Signature Print Name Date

- **PAYMENTS ARE EXPECTED AT THE TIME OF SERVICES RENDERED**
  - **ALWAYS** present your insurance card upon arrival. We contact your insurance provider to determine your coverage status at the time of service.
  - We submit claims to insurers and ask that you promptly pay applicable co-pays, co-insurances, or deductibles at the time of the visit.
  - The responsibility for payment of services rendered to any minor children rests with the parent or guardian who seeks treatment. We do not get involved in child custody matters.
  - *Your insurance policy is a contract between you, your employer(s), and your insurance company. Therefore, you are responsible for understanding your specific policy, co-pays, and deductions.*
- **NOTIFICATION OF CHANGES**
  - You are responsible for informing our office of any insurance, address, or contact information changes. If your insurance is found to be inactive at the time of service, self-pay charges will be applied to your account.
- **NEWBORN CHARGES**
  - New parents are responsible for notifying Tenney Pediatrics with the child's insurance information. Your infant will not be automatically enrolled into your insurance until you notify them of the birth. As a courtesy to new parents, we allow up to 30 days for you to notify your insurance carrier. After this time, you will be billed for the balance.
- **METHODS OF PAYMENTS**
  - We accept cash, personal checks (MO and KS only), VISA, MASTERCARD, AMERICAN EXPRESS, DISCOVER, money orders, cashiers' checks, and debit cards. There is a service charge for returned checks and credit transactions.
- **REFUNDS**
  - Overpayments will either be credited to the patient account or refunded upon written request.
- **MISSED APPOINTMENTS**
  - Missed appointments represent a cost to Tenney Pediatrics, and to other patients who could have been treated in the time set aside for your visit. Cancellations are requested within 24 hours of appointment, and there is a charge applied to your account for missed appointments with no prior notification that is subject to change. Excessive missed appointments may result in a discharge from Tenney Pediatrics.
    - **Missed Appointment Charge-Medicaid: $15**
    - **Missed Appointment Charge-Commercial Insurance: $25**

If you have any questions regarding our office policies or fees, please do not hesitate to call us at (816) 444-8400.

I have read the above and agree to comply with the Tenney Pediatric Financial Policy:

Signature: _____ Date: _____

Printed Name: _____