Preferred Pharmacy _____

PATIENT INFORMATION Date ___/___/___

☐ New Patient ☐ Update ☐ STAMFORD ☐ NEW CANAAN

New England Pediatrics

CHILDREN DATE OF BIRTH

LAST	FIRST	CELL PHONE	SEX	M	D	Y
LAST	FIRST	CELL PHONE	SEX	M	D	Y
LAST	FIRST	CELL PHONE	SEX	M	D	Y
LAST	FIRST	CELL PHONE	SEX	M	D	Y

MOTHER Name/Employer GUARANTOR ☐ YES ☐ NO DATE OF BIRTH

LAST	FIRST		M	D	Y
HOME ADDRESS	CITY	STATE	ZIP		
HOME PHONE	CELL PHONE	HOME FAX	EMAIL		
COMPANY NAME		POSITION			
BUSINESS ADDRESS-STREET	CITY	STATE	ZIP		
BUSINESS PHONE	BUSINESS FAX				

FATHER Name/Employer GUARANTOR ☐ YES ☐ NO DATE OF BIRTH

LAST	FIRST		M	D	Y
HOME ADDRESS	CITY	STATE	ZIP		
HOME PHONE	CELL PHONE	HOME FAX	EMAIL		
COMPANY NAME		POSITION			
BUSINESS ADDRESS-STREET	CITY	STATE	ZIP		
BUSINESS PHONE	BUSINESS FAX				

INSURANCE

PRIMARY INSURANCE NAME	POLICY NUMBER	GROUP NUMBER *if any*
SUSCRIBER NAME	RELATION TO PATIENT	
SECONDARY INSURANCE NAME	POLICY NUMBER	GROUP NUMBER *if any*
SUSCRIBER NAME	RELATION TO PATIENT	

IN CASE OF EMERGENCY — Contact (if unable to reach parent):

LAST NAME	FIRST NAME	PHONE	RELATIONSHIP

Who may we thank for your referral? INTERNET ☐ _____ ADVERTISEMENT ☐ _____ PHYSICIAN REFERRAL ☐ _____

PATIENT REFERRAL ☐ _____ OTHER ☐ _____

Rosemary Klenk MD • Alan Morelli, MD • Todd Palker, MD • Jason Davis, MD • Elizabeth Cipolla, MD• Gretchen Crist, MD

NEW CANAAN • 183 Cherry Street, 06840 • 203.972.5232 • FAX 203.972.5234 • STAMFORD • 166 West Broad Street, 06902 • 203.323.1770 • FAX 203.348.1501 • www.nepeds.com

Guarantor Financial Agreement and Authorization for Treatment

PRACTICE POLICIES

- New England Pediatrics accepts cash, check or credit card as a form of payment.
- You will receive a monthly statement if you have a balance due. Patient balances more than 30 days overdue are subject to an 18% annual interest charge.
- If we must refer your account to a collection agency or law firm to collect an unpaid balance, you will have to pay the costs of collection as well as the unpaid balance in order to remain a patient of our practice.
- If your account is placed in collection for failure to pay an outstanding balance, we reserve the right to discontinue our services. If we take this action, we will send you a medical records release for your signature so that you may transfer care and records to a new physician.
- You are responsible for any bank charges associated with checks not honored by our bank.
- If there is an outstanding patient balance for more than 60 days, we cannot schedule well child care.
- Well visits not cancelled 24 hours before the scheduled time are subject to a $50 charge. Sick visits not cancelled at least 2 hours prior to the scheduled time are subject to a $25 charge.
- New England Pediatrics reserves the right to charge a reasonable and customary fee for the completion of forms and applications and the preparation of medical records for transfer. Payment is due upon receipt of the document(s).

IF YOU HAVE PRIVATE INSURANCE

- Professional services rendered are charged to the patient. Payment is expected when services are rendered.
- We will not bill your insurance company. New England Pediatrics will provide you with an “Attending Doctor Statement” or “Encounter Form” at each visit so that you may file a claim with your insurance company.

IF YOU HAVE A MANAGED CARE PLAN IN WHICH WE PARTICIPATE

- If you have a managed care plan in which we participate, you are responsible to provide us with current and accurate insurance information at each visit.
- You are responsible for fees incurred if we do not have your current insurance information at the time of service.
- Co-pays must be paid at the time of service. Failure to do so will result in an additional $10 charge.
- Your child’s name should appear on your insurance card (plan dependent).
- If a doctor’s name is required on the card as your Primary Care Provider (PCP), it must be the name of a New England Pediatrics doctor, otherwise full payment may be due at the time of the visit.
- You may be responsible for fees if routine services provided are not covered by your insurance plan, or if your insurance company denies payment for covered services.

I, _____ *print name of responsible party*

authorize New England Pediatrics to treat my child/children. I have read and agree to the financial terms outlined herein.

SIGNATURE OF RESPONSIBLE PARTY DATE

RELATIONSHIP TO PATIENT