Patient Information

_____ DOB:_____
Last Name First Name Middle

Gender: ❒ Male ❒ Female

Address: _____
Street City State Zip

Home Phone: (___) _____ Cell Phone: (___) _____

Primary Language Spoken (circle one) English Spanish French Italian Russian Korean Japanese Other _____

Siblings:

Name: _____ DOB _____ Name: _____DOB _____

Name: _____ DOB _____ Name: _____DOB _____

Name: _____ DOB _____ Name: _____DOB _____

Pharmacy: _____ Phone number (___)_____ Fax (___)_____

Parent(s) or Guardian(s) #1 Information

_____ DOB: _____
Last Name First Name

CHECK ONE: RELATIONSHIP TO PATIENT ❒ Mother ❒ Father ❒ Grandparent ❒ Foster Parent ❒ Other_____

Email Address: _____ Cell Phone: (____)_____

Address:_____

Employer: _____

Work Address :_____Work Phone:(____)_____

Parent(s) or Guardian(s) #2 Information

_____ DOB: _____
Last Name First Name

CHECK ONE: RELATIONSHIP TO PATIENT ❒ Mother ❒ Father ❒ Grandparent ❒ Foster Parent ❒ Other_____

Email Address: _____ Cell Phone: (____)_____

Address:_____

Employer:_____

Work Address:_____ Work Phone:(____)_____

IN CASE OF EMERGENCY, PLEASE PROVIDE THE NAME OF A **FRIEND** OR **RELATIVE** AT A **DIFFERENT ADDRESSS**:

_____Phone:(____)_____
Name Address Relationship to family

Other Persons Authorized to Accompany Patient During Visits (if applicable)

□ I authorize the person (s) listed below permission to accompany my child to the office and receive medical information pertaining to my child's care

Name: _____ Relationship to patient _____

Name: _____ Relationship to patient _____

Consent to Leave Messages

If we are unable to speak with you directly, we may need to leave a voice mail or answering machine message with detailed information about your child's condition or treatment, such as test results or the scheduling of procedures. Please check one:

□ Yes, you may leave detailed messages on □ Home_____ □ Cell _____

□ No, **DO NOT** leave detailed messages, generic messages only

We may also need to leave messages with detailed information about your child's condition or treatment, such as test results or the scheduling of procedures, with family members, or others who answer your home/cell phone. Please check one:

□ Yes, you may leave detailed messages with anyone who answers my phone

□ No, **DO NOT** leave detailed messages with anyone who answers my phone

Financial Responsibility

At Bryn Mawr Pediatrics we are dedicated to providing our patients with the best possible care and services. We ask your help by understanding and cooperation with our financial policy as is written below.

INSURANCE COVERAGE:

We participate with several different insurance companies. Please check with your insurance company to see if we participate with your plan.

It is your responsibility to be aware of you insurance coverage, policy provisions, exclusions, and limitations as well as authorization requirements. This information may also be obtained by contacting your insurance company.

We attempt to verify that your coverage is valid at the time of the visit. However, it is your responsibility to make sure that you provide us with your current insurance information. If we do not have current information you may be liable for the balance even if you were covered by insurance at the time of service. We will require you to present your insurance card at every visit.

If you have had any changes to your insurance coverage (co-payment amount, ID or group # change, etc.) you must notify us and/or present new insurance card.

REFERRALS:

If your insurance company requires a referral, we ask that you give us 48hr notice before the time of visit. We also ask that you provide us with the specialist name, address, and provider number or NPI. All referrals are done electronically.

BILLING AND PAYMENTS:

Our office accepts **Cash, Check, and Credit Card (Visa, Mastercard, & Discovery).** All payments are expected at the time of service.

It is our office policy to charge the following fees that are not billed to your insurance.

$6.00	small form fee (signature only)	$25.00	for returned checks
$12.00	form fee	$25.00	no show fee

There is also a fee to transfer records to another practice. (prices vary due to size of chart)

Health Insurance:

Primary Insurance:_____ Address:_____

Policy #:_____ Group #: _____

Subscriber's Name: _____ Subscriber's DOB: _____

Subscriber's Relationship to patient: ❒ Mother ❒ Father ❒ Grandparent ❒ Other _____

Secondary Insurance (if applicable): _____ Address: _____

Policy #:_____ Group #: _____

Subscriber's Name: _____ Subscriber's DOB: _____

Subscriber's Relationship to patient: ❒ Mother ❒ Father ❒ Grandparent ❒ Other _____

Assignment of Insurance Benefits: I hereby authorize direct payment of medical/surgical benefits to Bryn Mawr Pediatrics for services rendered by Wenonah Nelson, M.D, Karla Nickolas-Swatski, M.D. and Rebecca A. Drusah, D.O. or under his/her supervision. I understand I am financially responsible for any balance not covered by my insurance unless my insurance contract specifies otherwise.

Authorization to release information: I hereby authorize Bryn Mawr Pediatrics to release any medical or incidental information that may be necessary for either medical care or in processing applications for insurance payment.

A copy of these assignments shall be valid as the original. These assignments shall remain in effect until revoked by me in writing.

I have read and fully understand the financial policy set forth by Bryn Mawr Pediatrics and I agree to the terms of this financial policy.

_____ _____

Signature of Patient/Parent/Guardian Date

Receipt of Notice of Privacy Practices Written Acknowledgement Form

□ I have received a copy of Bryn Mawr Pediatrics notice of Privacy Practices.
□ I have not received a copy of Bryn Mawr Pediatrics notice of Privacy Practices.

Signature _____ Date:_____