



Box Hill Pediatrics

39 Kensington Parkway
Abingdon, MD 21009

Phone 410-569-7337 / Fax 410-569-7347

info@boxhillpediatrics.com

http://www.boxhillpediatrics.com

Patient Information & Benefits Record Release

form page 1 of 2

Instructions: Complete all appropriate fields. Please confirm all numbers and bring verification of health insurance with you to your first appointment.

PATIENT INFORMATION

Please list all children's names (last, first) & birth dates

Name: _____ DOB: _____ SS#: _____

Name: _____ DOB: _____ SS#: _____

Name: _____ DOB: _____ SS#: _____

Name: _____ DOB: _____ SS#: _____

Name: _____ DOB: _____ SS#: _____

Address: _____

Home Phone: _____ Cell: _____ Pager: _____

Primary Email (one that is checked frequently) _____

Mother's Name: _____ DOB: _____ SS#: _____

Employer: _____ Phone: _____

Father's Name: _____ DOB: _____ SS#: _____

Employer: _____ Phone: _____

Patient Responsibility Party: _____

Person responsible for paying your medical bills, other than Ins. Co.

Emergency Contact: _____ Phone: _____

Primary Insurance: _____

Claims Address: _____

Membership #: _____ Co-Pay: _____

Subscriber: _____ Relationship: []-Self []-Spouse []-Child

Secondary Insurance: _____

Claims Address: _____

Membership #: _____ Co-Pay: _____

Subscriber: _____ Relationship: []-Self []-Spouse []-Child

PLEASE READ AND SIGN REVERSE SIDE FOR GUARANTOR LIABILITY & OFFICE POLICES.



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Patient Information & Benefits Record Release form page 2 of 2

PATIENT BENEFITS/RECORD RELEASE

Your Name

Please Print

AUTHORIZATION

I authorize Box Hill Pediatrics, L.L.C. to release medical information as it is necessary to bill my insurance carrier. In addition, I authorize my insurance carrier to release payments of insurance benefits directiv to Box Hill Pediatrics.

Signature: _____ Date: _____

CO-PAYS

All co-pays will be due before the doctor sees you. Co-pays are also collected even when visits are for immunizations, venipuncture, and allergy shots only. Also if you have not met you deductible for the year, payment is required when services are rendered.

Signature: _____ Date: _____

REFERRAL POLICY

I agree to abide by my insurance policy's rules regarding referrals to specialists and ancillary services (i.e using specialists and ancillary services within my insurance plan and network). I understand that Box Hill Pediatrics LLC has a policy, which includes requesting referrals at least I week prior to your specialist visit. No post?dated referrals will be issued.

Signature: _____ Date: _____

GUARANTOR LIABILITY RESPONSIBILITY

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have completed all of the abovequestions and I certify that the information is true and correct to the best of my knowledge. I will notify the office of any changes in the above information, insurance status or health status. I authorize payment of medical benefits to Box Hill Pediatrics LLC for services rendered to me. I also understand and agree that in case of default I will be responsible for all attorney fees and collection fees incurred on this account.

I also understand I am liable for knowing and understanding my insurance coverage. This includes that you must be the designated Primary Care Physician and/or primary site at the time services are rendered, or I will become responsible for any payment due. I am also responsible for knowing my insurance polices with regards to well and sick visits as well as immunization coverage. Please inform the office staff if your insurance policy does not coverage vaccines, or if you have no insurance coverage. (Your child may be eligible for State of Maryland Health Department vaccine coverage). I am also advised that many insurance carriers will only pay for services that it determines to be reasonable and necessary. Box Hill Pediatrics, LLC believes that your physician is in the best position to know the clinical assessment needs of his or her patients. In some cases, when a physician orders a specific test to either detect presymptomatic diseases as part of a process to help determine what the diagnosis is some insurers will not pay for the test performed in this case, you would be responsible for any charges incurred. (You may always check your coverage by calling your insurance carrier).

Signature: _____ Date: _____