HACKENSACK PEDIATRICS
177 SUMMIT AVENUE
HACKENSACK, NJ 07601
Tel: 201-487-8222; Fax: 201-487-2126

HACKENSACK PEDIATRICS
PEDIATRIC AND ADOLESCENT MEDICINE

Patient/Child's Name _____ **Date of Birth:** _____

INSURANCE INFORMATION

PRIMARY INSURANCE:

Policy Holder Name: _____ Relationship to Patient: _____

Date of Birth: _____ Social Security Number: _____

Patient's ID#: _____ Patient's Group#: _____

Effective Date: _____ Today's Date: _____

SECONDARY INSURANCE:

Policy Holder Name: _____ Relationship to Patient: _____

Date of Birth: _____ Social Security Number: _____

Patient's ID#: _____ Patient's Group#: _____

Effective Date: _____ Today's Date: _____

Please list all children who currently are, or will be, patients at Hackensack Pediatrics

Name: (last, first MI)	Sex (M/F)	Date of Birth:	Same Insurance?
_____	_____	_____	Y / N
_____	_____	_____	Y / N
_____	_____	_____	Y / N
_____	_____	_____	Y / N
_____	_____	_____	Y / N

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RESPONSIBLE PARTY (GUARANTOR)

Responsible party (Guarantor) is the individual who agrees to accept financial responsibility for the payment of all services performed at Hackensack Pediatrics. This individual may not necessarily be the insurance cardholder. Responsible Party must read and sign below.

Name _____ Relationship to Patient _____

Address _____

E-mail Address: _____ Occupation: _____

Social Security Number: _____ Phone (Home): _____

(Cell): _____ (Other Phone #): _____

I certify that the information I have reported with regards to my insurance coverage is correct. I authorize the release of any medical information necessary to process all claims and I permit a copy of this authorization to be used in place of the original. I also acknowledge that all unpaid charges are subject to a service charge of 2.5% per month after 60 days from date of service. Additionally, all Copays must be paid at the time of the visit. If a copay is not paid at the time of the visit, I agree to pay a $10 admin/penalty fee in addition to the unpaid copay amount. For any balances paid on a payment plan, I agree to pay a $10 admin fee per payment until balance is paid in full. For all appointments, I agree to pay a $25 no-show fee for any appointments where I do not show-up, or for appointments when I cancel less than 24 hours prior to the appointment. Furthermore, I agree to pay any collection costs and legal fees incurred by this office with respect to these charges.

SIGNATURE: _____ DATE: _____

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of surgical/medical benefits to the PHYSICIANS/NPs at HACKENSACK PEDIATRICS for services rendered by them in person or under their supervision. I understand that I am financially responsible for any balance not covered by my insurance.

NAME: _____

SIGNATURE: _____ DATE: _____

CHILD ADVOCACY

As advocates for our young patients, Hackensack Pediatrics will not intervene in any custody disputes, or financial responsibility disputes, between parents or other responsible parties. The office will send statements to the address provided. However, we will not look to more than one party to fulfill financial responsibility.

NAME: _____

SIGNATURE: _____ DATE: _____