WILDWOOD PEDIATRICS
AND ADOLESCENT MEDICINE, LLC

ONE WILDWOOD MEDICAL CENTER, ESSEX, CT 06426
30 Elm Street, Old Saybrook, CT 06475

Patient Information

Patient Name _____ Date of Birth _____ Sex ☐ M ☐ F

Federal regulations require that we ask the following regarding *this patient*.
Languages ☐ English ☐ Spanish ☐ Other _____ ☐ Decline to answer
Ethnicity ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Other ☐ Decline to answer
Race ☐ American Indian ☐ Asian ☐ Caucasian ☐ African American ☐ Other ☐ Decline to answer

Mailing Address _____ City _____ State _____ Zip _____

Residence *(NOT P.O Box)* _____ City _____ State _____ Zip _____

For patients 13 yrs & older (otherwise leave blank): Cell Phone _____ Email _____

For patients 18 yrs & older (otherwise leave blank):
Preferred contact for appointment reminders ☐ Email ☐ Text to cell phone ☐ Call cell phone
Preferred contact for medical information ☐ Email ☐ Text to cell phone ☐ Call cell phone
Preferred contact for patient portal notifications ☐ Email ☐ Text to cell phone

Parent/Guardian Information

Parent/Guardian 1 (*Last, First*) _____ Date of Birth _____

Relationship to Patient _____ Languages ☐ English ☐ Spanish ☐ Other _____

Street Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email _____ SSN (for billing) _____

Employer _____ Occupation _____

Preferred contact for appointment reminders ☐ Email ☐ Text to cell phone ☐ Call cell phone ☐ Call home phone
Preferred contact for medical information ☐ Email ☐ Text to cell phone ☐ Call cell phone ☐ Call home phone
Preferred contact for patient portal notifications ☐ Email ☐ Text to cell phone

Parent/Guardian 2 (*Last, First*) _____ Date of Birth _____

Relationship to Patient _____ Languages ☐ English ☐ Spanish ☐ Other _____

Street Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email _____ SSN (for billing) _____

Employer _____ Occupation _____

Preferred contact for appointment reminders ☐ Email ☐ Text to cell phone ☐ Call cell phone ☐ Call home phone
Preferred contact for medical information ☐ Email ☐ Text to cell phone ☐ Call cell phone ☐ Call home phone
Preferred contact for patient portal notifications ☐ Email ☐ Text to cell phone

Who should be contacted first regarding appointments and patient medical information
☐ Parent/Guardian 1 ☐ Parent/Guardian 2 ☐ Patient (18 and older)

Parents/Guardians are ☐ Married ☐ Divorced ☐ Separated ☐ Single ☐ Other (*Specify*) _____
Patient mainly lives with ☐ Mother ☐ Father ☐ Both
☐ Grandparent ☐ Foster Parent ☐ Other (*Specify*) _____

Emergency contact other than parent/guardian

Name _____ Relationship to Patient _____ Phone _____

Address _____ City _____ State _____ Zip _____

Health Insurance & Billing Information

Responsible Party Name _____ Primary Phone _____

Address _____ City _____ State _____ Zip _____

Federal and State Government's Vaccine for Children Program requires us to ask you to check off any of the following that apply to *this patient*:

☐ Enrolled in Medicaid ☐ Uninsured ☐ American Indian/Alaska Native ☐ Health insurance does not cover vaccines

Please Check one ☐ If you have no health insurance, please check this box and initial here: _____

☐ All others please check this box and fill out your insurance information below.

Primary Health Insurance Company's Name _____ Policy ID# _____

Type of Contract/Plan Name _____ Effective Date _____

Policy Holder's Name _____ Birth Date _____

Policy Holder's Address _____

Secondary Health Insurance Company's Name _____ Policy ID# _____

Type of Contract/Plan Name _____ Effective Date _____

Policy Holder's Name _____ Birth Date _____

Policy Holder's Address _____

Please list all children/siblings – including patient from page 1 (under 23 years of age) who live at the same residence. For each child, circle C (covered) or NC (not covered) for each insurance plan that you have listed.

Last name, First name	M/F	Date of Birth	Primary Ins	Secondary Ins
			C / NC	C / NC
			C / NC	C / NC
			C / NC	C / NC
			C / NC	C / NC
			C / NC	C / NC
			C / NC	C / NC

Please present your insurance card for copying.

Note: even though we make a copy, your insurance carrier requires you to present the patient's card at each and every visit.

These two statements *must* be signed:

I certify that the information listed on this form is current and correct.

Signed: _____ Date _____

I certify that I have received a copy of the practice privacy policies.

Signed: _____ Date _____

I certify that I have read and understand the policies outlined on all pages of this form. My signature signifies that I agree to abide by these policies, and to be financially responsible for all bills related to my family's care at Wildwood Pediatrics and Adolescent Medicine. I authorize Wildwood Pediatrics and Adolescent Medicine to release medical information that may be necessary to request claim reimbursement. I hereby authorize and direct my insurance benefits to be paid directly to Wildwood Pediatrics and Adolescent Medicine. **I understand that I am financially responsible for all co-payments and any charges not covered under my insurance benefits. Payment of co-pays are due on the date of service. Failure to pay co-pay at that time will result in an additional billing charge.** I understand that I am liable for any and all costs of billing and collection.

Signed: _____ Date _____

Payment Policy

Payment is expected at the time services are rendered unless prior arrangements have been made. Cash, check, Discover, MasterCard, Visa, and American Express are accepted.

We are "participating physicians" in several health plans. These change from time to time, so if you are in doubt about the status of your plan, please check. Participants must be aware that their current, valid health plan identification card serves as their "credit card" for medical services in our office. **The card must be presented at the time of each and every visit.** Any services that the health plan denies payment for, for any reason, are the **personal responsibility of the patient**, and as such are immediately payable in full.

Charging privileges my be granted upon special request. **All charges are payable in full within 30 days.** Any and all costs associated with billing and collection proceedings, including any and all reasonable attorney's fees, are the responsibility of the patient. All balances over thirty days (30 days) may be subjected to a finance charge of 1½% a month (18% a year).

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A Special Note Regarding the Confusing Issue of Third Party Payments by Insurance Companies and Ex-Spouses

By law, both parents are responsible for their minor (under 18) children's debts. While we will send a statement to whomever is designated on this form, each parent must be held wholly liable for timely full payment for care delivered by the practice, as well as any other fees incurred. Divorce proceedings do not alter this basic responsibility. Court judgments that one parent is "responsible" refers to the relationship between the parents; it does not affect the contract with a medical office. Agreements with insurance companies are similar. Thus, waiting for an ex-spouse's or insurance company's payment is not an adequate reason for late payment of fees.

A very few patients who have health plan insurance (Aetna, CIGNA, Anthem Blue Cross and Blue Shield of Ct, Connecticare, United Healthcare, Husky Health and Medicaid) are also covered by other insurance. Unless we are participating members *and* the health plan is the primary carrier, in order to prevent confusion; all charges incurred by these families are treated as personal charges. Why is this? The health plans will refuse to pay unless we submit a denial from the other (primary) carrier, but only the patient is able to get such a denial. Time limits for submission to the health plans elapse (within as few as 60 days), and the charges go unpaid forever. If you fall into this category, please discuss the situation with our Billing Department.

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"Uncovered" Services

This paragraph fulfills any "prior notification" requirement your carrier may require contractually of our practice regarding any and all uncovered services. Please read it carefully. Each health care plan and insurance policy (including Medicaid plans) has services that it specifically excludes. Some examples are extended visits, physical examinations that are "too close" together, after hours care (CPT 99050), holiday, weekend or evening care charges (CPT 99051), and walk-in/emergency charges (CPT 99058). There is often no consistency in their rulings, and each patient/family must read the "fine print" of their own policy. By requesting or accepting a service, a patient (and guarantor) hereby agrees to be personally responsible for payment. That is that (you) agree that any services that the health plan (or Medicaid) denies payment for, for any reason, are the personal responsibility of the patient, and as such are immediately payable in full.

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Essex Office	**Old Saybrook Office**
Telephone (860) 767-0168	Telephone (860) 388-4545
Facsimile (860) 767-1803	Facsimile (860) 395-2960

www.wildwoodpediatrics.com