BABI PEDIATRICS

Child's Name:_____ Male:___ Female:___
Race:_____ Ethnicity:_____ Language:_____
Birth Date:_____ SSN:_____ Phone:_____
Address:_____ City:_____ State: _____Zip:_____
Legal Guardian: Both Parents___ Mother___ Father___ Other_____
Legal Guardian Information: Married___ Single___ Divorced___ Other_____
Sibling_____ DOB _____ Sibling_____ DOB _____
Sibling_____ DOB _____ Sibling_____ DOB _____

Father's Name:_____ Mother's Name:_____
DOB:___/___/___SSN:_____ DOB:___/___/___SSN:_____
Address:_____ Address:_____
City:_____ State:_____ City:_____ State:_____
Zip:_____DL#:_____ Zip:_____ DL#:_____
Home Phone:_____ Home Phone:_____
Cell Phone:_____ Cell Phone:_____
Work Phone:_____ Work Phone:_____
Employer:_____ Employer:_____
Address:_____ Address:_____
Name of Insurance Company:_____
Insurance Appears in Whose Name?_____
Policy #:_____ Group#:_____
Emergency Relationship:_____
Contact:_____ Phone #:_____
Pharmacy_____#: _____ Address: _____

NON-COVERED SERVICES POLICY

Babi Pediatrics may at times provide services that are necessary or advisable for your continued health and well being, that may or may not be covered by your insurance company, HMO or health plan. You will be expected to pay for these services in full.
Please remember that insurance is considered a method of reimbursement for the fees paid to the doctor. It is not a substitute for payment. Some companies pay fixed allowances for certain procedures and other pay a percentage of charges. It is your responsibility to pay any deductible, co-payer balance left by your insurance.
IN ORDER TO CONTROL THE COST OF BILLING, WE REQUEST THAT OUR CHARGES BE PAID AT THE CONCLUSION OF EACH VISIT.
COLLECTIONS: If this account is assigned to a collection agency or to an attorney for collection and/or suit, you will be responsible for all attorneys' fees and cost of collection 33.33%. You further agree to waive all rights of exemption: as to personal property granted under the Constitution of the United States and the laws of the State of Alabama.
AUTHORIZATIONS: To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's medical record, including Info Solutions, if applicable. I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled to Babi Pediatrics. This assignment will remain in effect until revoked by me in writing. A photocopy and/or fax of this assignment are to be considered as valid as the original. I understand that I am financially responsible for ALL charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.
I, the undersigned parent (or guardian) of the above child (children) authorize any of the physicians of Babi Pediatrics to give any treatment or immunization to my child when brought in by myself or another responsible party, or if teenager, when alone.
APPOINTMENTS NOT CANCELED 24HRS IN ADVANCE WILL INCUR A $15.00 FAILURE TO CANCEL FEE.
I certify that all of the above information is correct and the insurance is in effect as of today. I have read the above policy and agree to pay for all service not covered by my insurance. I understand that it is my responsibility to verify and know my insurance policy and my PCP.

SIGNED:_____RELATIONSHIP:_____DATE:_____