CORNERSTONE PEDIATRICS ASSOCIATES, INC

Today's date ________________

RESPONSIBLE PARTY (parent who carries insurance)

Name ____ Birth Date ________________

Street Address ____

City ___________________ State _____ Zip _________ Cell# ____________________

Home Phone __________________________ Work Phone _______________________

Relationship to patient __________________ Employer _________________________

SS# ____________________________ Occupation _____________________________

SELF

Name _______________________________________ Birth Date __________________

Street Address ____

City __________________________ State ___ Zip _________ Cell # ________________

Home Phone _____________________ Work Phone ______________________

SS# ____________________________ Employer ________________________________

Email address ____

EMERGENCY CONTACT (Relative or friend living with you)
Name ___________________________________ Relationship _____________________
Phone _______________________

PLEASE READ AND SIGN THE OTHER SIDE

I give permission for ________________________ to make medical transactions for me
(Parent Name)
as well as accessing all of my medical records, for the period of 1 physical year.

PLEASE READ AND SIGN Name:____________________DOB:__________

CORNERSTONE PEDIATRIC ASSOCIATES POLICIES

1. A copy of the patient's insurance card is required on each and every visit to us. It is the patient's responsibility to make sure that any insurance information given to our office is correct and current. Failure to provide such information will result in patient financial responsibility for all services. It will be my responsibility to list a physician if my insurance requires a PCP and call for a referral if one is required. _____
2. Co-payments are due at the time of service. We may ask that non-emergent appointments to be rescheduled if co-payment is not paid. _____
3. I understand that I am responsible for all charges incurred in this office, less any contracted insurance rates adjustments, in accordance with the regular (published) rates and terms of the office, regardless of insurance coverage. All deductibles, co-payments and co-insurances are due at the time of service. It is your responsibility to know your insurance coverage prior to your child's appointment. ______
4. We are not party to any legal agreements between divorced or separated parents. ______
5. All unpaid balances after being processed by insurance will incur a rebilling fee of $5.00 per month after 30 days. Should the account be referred for collection, you shall pay actual attorney's fees, collection expenses, and court costs. IF YOUR ACCOUNT IS REFERRED FOR COLLECTION, THE PRINCIPAL BALANCE WILL BE INCREASED BY 25%. _______
6. I understand that Cornerstone Pediatrics Assoc. requires that I carry a credit card or Health Savings card on file to be billed once insurance settles. This credit card will be automatically charged after insurance has processed the claim. If the credit card I provide is declined; I understand that I will be charged an extra $50.00 reprocessing fee. I understand I may put a secondary card on file to be used in the event my HSA account is out of funds._______
7. I understand that if well child visits and immunizations are not covered by my plan, I am responsible for paying for these visits at the time of service. Please note that some insurance carriers have a maximum on well coverage. Please verify your benefits. _____
8. If insurance is billed on my behalf by Cornerstone Pediatrics, I authorize my insurance company to make payments directly to them. I authorize the release of any medical information necessary to process claims and/or pursue payment of this account. _____
9. Cornerstone Pediatrics requires appointments to be cancelled at least 24 hours in advance. I understand I will be billed for missed appointments and those that do not adhere to our 24 hour cancellation policy. This policy applies regardless of the method of cancellation, whether it is through the portal, email, voice or answering service. _____
10. Once an appointment has been made, it is my responsibility to appear for the appointment. Any reminders received are a courtesy and do not replace my responsibility. _____
11. I may be asked to reschedule if I am more than 10 minutes late for appointment or if I go to the wrong office location. If I have to reschedule, I understand I will be assessed a missed appointment fee. _____
12. Daycare, camp, sports and school forms require 5 business days to complete. _____
13. If your insurance carrier requires a referral to a provider outside our office, you must contact our referral department 5 business days prior to an appointment. Failure to do so may result in you being financially responsible for those services provided by another office. _____

I acknowledge I have read and understand the Cornerstone Pediatric Associates Policies

____ ____________________

Signature of parent or guardian Date

Updated 04/06/2022