SILVERDALE  **PEDIATRICS**

INSURANCE / PATIENT PAYMENT COUNSELING & INFORMED FINANCIAL CONSENT

Patient Name: _____ DOB: _____ Visit Date:_____
Today's Date : _____

Primary Ins. Verification: _____ Reference#: (Date and Verifier's initials) _____

Contact Person:_____ Tele:_____

Insurance Name: _____

Insurance ID#: _____ Group #: _____

Insurance Active: ____ Effective date of Ins.: _____

Plan Type: PPO____ POS____ HMO____ EPO____ other_____

Are Dr. Niran or Dr. Saad Al-Agba In-Network/OON?: _____

PCP Sick Office Visit: ___ Co-Pay$_____ Co-Ins.:____ % Deductible: $____ Patient Responsibility: $ /visit

PCP on File: Referrals needed?

Wellness Exam: Co-Pay $ ____ Co-In. ____% Deductible: $ ____ Patient Responsibility: $____ /visit

Secondary Insurance: _____Co-Pay $ ____ , Co-In. ____%, Deductible: $____

Insurance ID#: _____ Group #: _____

General Note:

PATIENT/RESPONSIBLE PARTY ACKNOWLEDGEMENT OF OFFICE POLICIES AND FINANCIAL CONSENT

I, _____, understand that Silverdale Pediatrics LLP does insurance verifications as a ***courtesy*** for their patients. By signing this form, I am acknowledging that I have read and understood this Financial Guide. I understand that the benefits quoted are not a guarantee of payment by my insurance company and that my health insurance company(s) will receive claims for today's service from my physician.

Patient or Guardian Signature:_____ Date: _____

Internal Use: Credit -$____, Current Balance +$___, Past Due Balance +$___, Interest +$___, Today's Charge +$____, =Total$____