

# Beachside Pediatrics of Naples



| Child/Children Name(s) (first and last) | Date of Birth | Sex |
|---|---------------|-----|
|   |               | M F |
|   |               | M F |
|   |               | M F |
|   |               | M F |

### PARENT/GUARDIAN

Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
 Address: \_\_\_\_\_ Apt # \_\_\_\_\_  
 City/State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Cell Phone : \_\_\_\_\_ Alternative Phone: \_\_\_\_\_  
 Relationship to patients (circle): Mother Father Other \_\_\_\_\_ Email: \_\_\_\_\_  
 Employer: \_\_\_\_\_

### PARENT/GUARDIAN

Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
 Address: \_\_\_\_\_ Apt # \_\_\_\_\_  
 City/State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Cell Phone : \_\_\_\_\_ Alternative Phone: \_\_\_\_\_  
 Relationship to patients (circle): Mother Father Other \_\_\_\_\_ Email: \_\_\_\_\_  
 Employer: \_\_\_\_\_

### EMERGENCY CONTACT (other than parents)

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

### PATIENT PORTAL

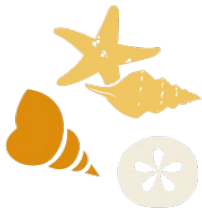
Our patient portal "My Kid's Chart" is an *essential component to our practice*. Once you receive your enrollment email you will have 1 week to complete enrollment before the link expires.

Preferred email for portal accountant:

\_\_\_\_\_

### PREFERRED PHARMCY

Name: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_



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## INSURANCE

Please provide us with a copy of your insurance card and drivers license. If your card is not available at the time of service we will allow you a two week grace period for new insurance cards to be submitted, after which the office visit will be considered your financial responsibility.

If you have an HMO policy please make sure Dr. Najm, Shannon Segaloff ARNP or Lisa Romano ARNP, is assigned as your child's PCP prior to your child's visit. In the scenario that the child is not assigned to either provider, the office visit will be considered your financial responsibility. We will be happy to accommodate you with self pay pricing. Self pay pricing is a discount and you will not be able to submit the claim to your insurance company for reimbursement.

I hereby authorize Beachside Pediatrics to furnish information to insurance carriers concerning my child's illnesses and treatments and I hereby assign to the physician all payments for medical services rendered. I understand I am responsible for any amount not paid by my insurance company. If my insurance company or any other insurance company handling my claim does not pay my claim within 90 days, I will pay Beachside Pediatrics and wait for my insurance to reimburse me. ***If collection proceedings become necessary, I agree to pay for any costs incurred in collecting and the outstanding balance due.***

Primary Insurance Company: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Policy holder's name: \_\_\_\_\_ DOB: \_\_\_\_\_

Policy #/ ID: \_\_\_\_\_ Group #: \_\_\_\_\_

*If you would like to keep your HSA or credit card on file please speak to front desk personnel.*

You will be responsible for full amount of payment at the time of service for the following reasons:

1. You do not have insurance.
2. You are covered by a company that Beachside Pediatrics is not contracted with.
3. Your child receives a service that is not covered by your policy. For example some plans do not cover certain immunizations, vision screenings, or developmental screenings.
4. Your insurance company denies your claim for any reason that is not resolvable.
5. You did not provide us with updated insurance information resulting in claim denial due to filing deadlines.
6. You didn't verify that Dr. Najm or Lisa Romano, APRN is the assigned PCP for your HMO insurance policy at the time of service.
7. Your insurance company does not pay the claim within 90 days.

Signature of parent or guardian \_\_\_\_\_ Date \_\_\_\_\_