PATIENT INFORMATION Date ___/___/___

☐ New Patient ☐ Update ☐ STAMFORD ☐ NEW CANAAN

New England Pediatrics

PREFERRED PHARMACY _____

CHILDREN DATE OF BIRTH

LAST	FIRST	CELL PHONE	SEX	M	D	Y
LAST	FIRST	CELL PHONE	SEX	M	D	Y
LAST	FIRST	CELL PHONE	SEX	M	D	Y
LAST	FIRST	CELL PHONE	SEX	M	D	Y

PARENT 1 Male ☐ Female ☐ GUARANTOR ☐ YES ☐ NO DATE OF BIRTH

LAST	FIRST		M	D	Y
HOME ADDRESS	CITY	STATE	ZIP		
HOME PHONE (PRIMARY ☐)	CELL PHONE (PRIMARY ☐)	EMAIL			
COMPANY NAME		POSITION			
BUSINESS ADDRESS-STREET	CITY	STATE	ZIP		
BUSINESS PHONE	BUSINESS FAX				

PARENT 2 Male ☐ Female ☐ GUARANTOR ☐ YES ☐ NO DATE OF BIRTH

LAST	FIRST		M	D	Y
HOME ADDRESS	CITY	STATE	ZIP		
HOME PHONE (PRIMARY ☐)	CELL PHONE (PRIMARY ☐)	EMAIL			
COMPANY NAME		POSITION			
BUSINESS ADDRESS-STREET	CITY	STATE	ZIP		
BUSINESS PHONE	BUSINESS FAX				

INSURANCE

PRIMARY INSURANCE NAME	POLICY NUMBER	GROUP NUMBER *if any*
SUSCRIBER NAME	RELATION TO PATIENT	
SECONDARY INSURANCE NAME	POLICY NUMBER	GROUP NUMBER *if any*
SUSCRIBER NAME	RELATION TO PATIENT	

IN CASE OF EMERGENCY — Contact (if unable to reach parent):

LAST NAME	FIRST NAME	PHONE	RELATIONSHIP

Who may we thank for your referral? INTERNET ☐ _____ ADVERTISEMENT ☐ _____ PHYSICIAN REFERRAL ☐ _____

PATIENT REFERRAL ☐ _____ OTHER ☐ _____ WELCOME WAGON ☐

ROSEMARY KLENK, MD • ALAN MORELLI MD • TODD PALKER, MD • JASON DAVIS, MD • ELIZABETH CIPOLLA, MD • ELENA GAZZOLA, MD

NEW CANAAN • 183 Cherry St., 06840 • 203.972.5232 • FAX 203.972.5234 • STAMFORD • 31 Strawberry Hill Ave.,06902 • 203.323.1770 • FAX 203.348.1501 • www.nepeds.com

Guarantor Financial Agreement and Authorization for Treatment

PRACTICE POLICIES

- New England Pediatrics accepts cash, check or credit card as a form of payment.
- You will receive a monthly statement if you have a balance due. Patient balances more than 30 days overdue are subject to an 18% annual interest charge.
- If we must refer your account to a collection agency or law firm to collect an unpaid balance, you will have to pay the costs of collection as well as the unpaid balance in order to remain a patient of our practice.
- If your account is placed in collection for failure to pay an outstanding balance, we reserve the right to discontinue our services. If we take this action, we will send you a medical records release for your signature so that you may transfer care and records to a new physician.
- You are responsible for any bank charges associated with checks not honored by our bank.
- If there is an outstanding patient balance for more than 60 days, we cannot schedule well child care.
- Well sick visits not cancelled 24 hours before the scheduled time are subject to a $50 charge. Sick visits not cancelled at least 2 hours prior to the scheduled time are subject to a $25 charge.
- New England Pediatrics reserves the right to charge a reasonable and customary fee for the completion of forms and applications and the preparation of medical records for transfer. Payment is due upon receipt of the document(s).
- I understand New England Pediatrics (NEP) may obtain my prescription history and preferred medications from a centralized database to assist in my care and I authorize NEP to do so.

IF YOU HAVE PRIVATE INSURANCE OR ARE UNINSURED

- Professional services rendered are charged to the patient. Payment is expected when services are rendered.
- We will not bill your insurance company. New England Pediatrics will provide you with an “Attending Doctor Statement” or “Encounter Form” at each visit so that you may file a claim with your insurance company.

IF YOU HAVE A MANAGED CARE PLAN IN WHICH WE PARTICIPATE

- If you have a managed care plan in which we participate, you are responsible to provide us with current and accurate information at each visit.
- You are responsible for fees incurred if we do not have your current insurance information at the time of service.
- Co-pays must be paid at the time of service. Failure to do so will result in an additional $10 charge.
- Your child’s name should appear on your insurance card (plan dependent).
- If a doctor’s name is required on the card as your Primary Care Provider (PCP), it must be the name of a New England Pediatrics doctor, otherwise full payment may be due at the time of the visit.
- You may be responsible for fees if routine services provided are not covered by your insurance plan, or if your insurance company denies payment for covered services.

I, _____ *print name of responsible party*

authorize New England Pediatrics to treat my child/children. I have read and agree to the financial terms outlined herein.

SIGNATURE OF RESPONSIBLE PARTY DATE

RELATIONSHIP TO PATIENT

ROSEMARY KLENK, MD • ALAN MORELLI MD • TODD PALKER, MD • JASON DAVIS, MD • ELIZABETH CIPOLLA, MD • ELENA GAZZOLA, MD
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