WIMBERLEY PEDIATRICS
& ADOLESCENT MEDICINE, PA

TIGER CLINIC
PEDIATRICS

Alternative Contact (*Must be a person not living within the same household):*

Name	Relationship	( ) - Phone Number

Insurance Information:

(If covered by more than one insurance policy, please enter the information for the primary plan & give information for secondary plans on the back of this form)

Name of Primary Insurance Company	Effective Date on Card
	/ /

Name of Primary Insured Person (Policy Holder)	Date of Birth	Insurance ID Number	Group Number
	/ /		

Is your child covered by other insurance plans? **Y** **N**

Consent for Treatment:

I do hereby consent to necessary examination procedures and/or treatments prescribed by my physician Dr. Roger Pruitt and/or his medical staff as is it necessary in his judgment. We invite you to discuss any questions or concerns regarding our services. The best medical service is based on a friendly, mutual understanding between physician, parent and patient.

Financial Responsibility:

Our office policy requires payment in full for all medical services rendered at the time of the visit. The person bringing the patient to this office is responsible for the charges unless other arrangements have been made in advance with our front office. **If the account is not paid within 90 days of the date of service, and no financial arrangements have been made, you will be responsible for any expenses incurred in collecting your account.** I hereby authorize payment of medical benefits directly to the physician for services rendered. I further authorize the physician to release any information required to process insurance claims. If my insurance is a PPO/HMO with which Wimberley Pediatrics contracts with, I am responsible for my co-pay, deductibles and non – covered services. I understand the above information and guarantee this form was completed correctly to the best of my knowledge, and understand I am responsible for informing this office of any changes in my child's medical insurance status.

Cancellation/ No- Show Policy:

Out of courtesy to other patients, there will be **a $75 fee** for all consultations cancelled or failure to show with less than a **24 hour** notice. **This charge is NOT billable to insurance, therefore becomes the responsibility of the parent or guardian of the patient. Further appointments other than sick visits, will not be scheduled prior to payment.**

Our office makes every effort to call at least 1 day in advance to confirm appointments. If we cannot contact you, it then becomes **your** responsibility to confirm appointments or notify us in advance of any need to cancel or reschedule.

Signature of Responsible Party	Relationship to patient	Date
		/ /

Wimberley Pediatrics & Adolescent Medicine
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