

Welcome To Our Office

UNIVERSITY FAMILY MEDICINE CENTER, PA
Pediatric Information (under 18)

Thank You for choosing our office. In order to serve you better please print the following information.

PATIENT NAME Last _____ First _____ MI _____
Address _____ Apt/Bldg. # _____ City _____ State _____ Zip _____
Sex M _____ F _____ Date of Birth _____ Age _____ School _____

RESPONSIBLE PARTY- Guardian or Parent (Circle One)
Name Last _____ First _____ MI _____
Relationship to Patient _____ Parent's/ Guardian's Name _____
Mailing Address _____ E-mail _____
Sex M _____ F _____ Home Phone _____ Work Phone _____
Date of Birth _____ SSN _____ - _____ - _____ Age _____
Employer _____ Spouse's Name _____
Spouse's Employer _____ Work Phone (_____) _____

Insurance Information- Please provide insurance card and driver's license
Policy Holder's Name _____ Relationship to Patient _____
Insured's SS # _____ Insured's Date of Birth _____

IN CASE OF EMERGENCY, NOTIFY:
Name _____ Relation _____ Phone _____
Address _____ City _____ State _____ Zip _____

METHOD OF PAYMENT Insurance (Please complete below) Cash Check Credit Card
HOW DID YOU LEARN OF UPMC, PA? _____

I consent to treatment and authorize the release of medical information necessary to obtain payment of medical benefits from my health insurance company and I authorize my insurance company to pay UNIVERSITY FAMILY MEDICINE CENTER, PA any medical benefits due me their services. I understand that I am responsible to pay deductibles, co-pays and any other charges not paid by my insurance company. **Our policy is that payment is expected in full at time services are rendered**, unless other financial arrangement are made in advance. If you participate with one of our contracted insurance programs, we will bill your insurance company for the initial filing. You are responsible for repeat filing of insurance or filing to secondary insurance. **CO-PAYMENTS AND DEDUCTIBLES ARE DUE AT THE TIME OF YOUR OFFICE VISIT.** Therefore, verification of your insurance, deductible, and co-payment in advance of your office visit will be necessary. Should a minor ever need medical attention and you are unavailable to give consent, this signed statement will serve as authorization for any provider at UPMC, PA to proceed with whatever medical care is necessary until you can be reached.

****NOTE**** Whoever presents with the child for their doctors visit is responsible for payment.

Signature: _____ **Date:** _____

Print Name: _____