



653 N. Town Center Drive, Ste. 106
Las Vegas, Nevada 89144
Phone: (702) 363-3000
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PATIENT INFORMATION FORM

Patient's Last Name _____ First Name _____ MI _____ Male/Female _____
Street Address _____ City _____ State _____ ZIP _____
Home Phone Number _____ Parent's Cell Phone/Pager _____ Date of Birth _____ Age _____

Mother's Last Name _____ First Name _____ MI _____
Street Address _____ City _____ State _____ ZIP _____
Home Phone Number _____ Work Phone Number _____ Employer _____ Date of Birth _____ Marital Status _____
Driver's License No. _____ Social Security No. _____

Father's Last Name _____ First Name _____ MI _____
Street Address _____ City _____ State _____ ZIP _____
Home Phone Number _____ Work Phone Number _____ Employer _____ Date of Birth _____ Marital Status _____
Driver's License No. _____ Social Security No. _____

Primary Insured's Name _____ Relationship to Patient _____ Social Security No. _____
Primary Insurance Carrier _____ Policy # _____ Group # _____
Insurance Claims Address _____ City _____ State _____ ZIP _____
Employer's Claims Address _____ City _____ State _____ ZIP _____

Emergency Contact (OTHER THAN PARENT) _____ Phone _____ Relationship to Patient _____

PLEASE COMPLETE BOTH SIDES OF THIS FORM. THANK YOU.

Sibling Name	Date of Birth	Age
Sibling Name	Date of Birth	Age
Sibling Name	Date of Birth	Age

YOU ARE FINANCIALLY RESPONSIBLE FOR ALL CHARGES INCURRED, REGARDLESS OF INSURANCE!

1. You agree to pay all insurance co-pays at the time of check-in and prior to services being rendered.
2. If Sunshine Valley Pediatrics cannot verify your insurance at the time of visit, or if you do not bring current proof of insurance to each visit, you agree to pay charges in full before the patient can be seen.
3. You will receive a statement showing in detail, charges incurred during the statement period and the amount due. Any uncollected fees are payable within 15 days of receiving the statement. You are responsible for complete payment of any charges that you incur whether covered by your insurance or not covered by your insurance. A finance charge of 1.5% per month or 18% annually will be incurred 30 days following the date the services were provided. If your account becomes delinquent and referred to a collection agency, you will be responsible for the costs of collection and/or legal fees. All accounts that are 90 days past due will automatically be assigned to a collection agency, regardless of insurance coverage. Accounts assigned to collections will include a 35% collection and processing fee.
4. If you miss an appointment without 24-hour prior notification to this office, you agree to pay a \$35.00 charge.
5. You agree to pay a \$25.00 charge, in addition to the check amount, on any of your personal checks which are returned to this office by our bank.
6. While your appointment may be for a specific time, no express or implied guarantee is made that a nurse or physician will see you at that exact time. Sunshine Valley Pediatrics makes every effort to see patients in a timely fashion, subject to patient volume and emergencies beyond our control. You agree not to hold Sunshine Valley Pediatrics responsible in any manner for time spent waiting to be seen.
7. You agree and understand that Sunshine Valley Pediatrics does not bill secondary insurance companies.
8. If your insurance has not paid this office within 90 days, you agree to pay all charges which have been incurred by you or your dependents at the time of visit, regardless of your insurance company's instructions.
9. As the child's parent, I understand that it is my responsibility to make and attend all follow-up visits ordered by the doctor. I understand that the doctor would not order a follow-up visit if it was not important. I also understand that Sunshine Valley Pediatrics cannot call me and remind me that I need to make a follow-up appointment. Therefore, it is my responsibility to make the appointment and I accept all responsibility if I should fail to schedule or attend a follow-up visit.
10. As the child's parent, I understand that it is my responsibility to make and attend my appointments when referred to a specialist. I accept all responsibility if I fail to schedule or attend an appointment with a specialist.

PLEASE SIGN TO INDICATE YOU UNDERSTAND AND ACCEPT OUR POLICIES.

Responsible Party (Print)

Date

Responsible Party (Sign)