Client Information

Child's Name____ Date of Birth____________

Address ____

City _________________________ State ______ Zip _____________

Email ____

Phone __________________________

Primary Care Physician ____

Emergency Contact ________________________ Phone _______________________

Relationship to Patient ___________________________

Insurance Information

Primary Insurance Company____

Policy Holder ___________________________ Employer _____________________

Relationship to Patient ___________________________ Date of Birth _____________

ID or Policy # ______________________________ Group # _______________
Marketplace plan __yes ___no

Secondary Insurance Company____

Policy Holder ___________________________ Employer _____________________

Relationship to Patient ___________________________ Date of Birth _____________

ID or Policy # ______________________________ Group # _______________

Medical Information Release
I hereby authorize the release of any information, including the diagnosis and the records of any treatments or examinations rendered, to my insurance company or companies, third party payers, or other health care agencies. A photocopy of this assignment is considered as valid as the original. I also authorize the release of medical records or copies of such and request that they be transferred to Piller Child Development, LLC.

Assignment of Benefits
I request that payment of authorized insurance benefits be made on my behalf to Piller Child Development, LLC.

Signature ______________________________________ Date ________________

Consent for Care
I, the undersigned, to hereby agree and give my consent for Piller Child Development to furnish medical care and treatment considered necessary and proper in evaluating and treating my physical condition.

Signature ______________________________________ Date ________________

My signature on a facsimile copy, scanned copy, pdf file, or other reproduction of this document shall be as valid and binding as a signed original.

10631 S 51st St, Suite 8 Phoenix, AZ Phone 480-398-4280 Fax 480-398-4281

Payment and Cancellation Policy

Payment Policies
Piller Child Development, LLC does everything possible to minimize the cost of medical care. You can help a great deal by eliminating the need for us to bill you. The following is summary of our payment policy.

All payment is expected at the time of service
Payment is required at the time services are rendered. We have a contractual obligation (with your insurance company) to collect all co-pays and co-insurance. This includes applicable co-payments for participating insurance companies. Payment will be collected when you check in. We are unable to bill co pays to you or secondary insurances.

Outstanding Balance
Once payment is received from your insurance company, you will be billed for any remaining amount. Payment for outstanding balances is expected within 10 business days. Patients with an outstanding balance of 30 days overdue must make arrangements for payment prior to scheduling appointments. We realize that people have financial difficulty. Please communicate with our billing and collection staff so that they may assist to create a financial plan with you. If your account becomes delinquent by more than 60 days, we will be forced to forward it to a collection agency. If your account is sent to an outside collection agency, we will add a collection fee to your account balance. The collection fee we charge you will be equal to the amount that the collection agency charges us. You will be responsible for paying the full balance, including this fee. A fee of $25 will be applied to each returned check.

Insurance
We bill participating insurance companies as a courtesy to you. You are expected to pay your deductibles and co-payments at the time of service. If we have not received payment from your insurance company, you will be expected to pay the balance in full. **You are responsible for all charges.** Insurance cards must be provided at your first appointment. If your insurance company requires you to have a referral or authorization for therapy, please verify with our front office that a current referral or authorization is on file. Our office will put forth as much effort as possible to help obtain these documents, however, the **patient is ultimately responsible for any resulting costs that may be associated with your visits.**

Missed Appointments /Cancellations/Late Appointments
Missed appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. If you are unable to keep your appointment, please give 24-hours notice to avoid charge. Cancellations with less than 24 hour notice, short notice reschedule, or “no shows” will be subject to a $35 fee. “No show” on Saturday appointments are subject to a $50 fee. If you have more than 2 cancellations within a 4-week period or 2 or more “no shows,” we reserve the right to discontinue services. If more than 15 minutes late to an appointment, we reserve the right to charge a late appointment fee of $15.

Initials _____

Refunds
Overpayments will be refunded upon written request to the responsible party within 30 days of our office confirmation. Otherwise, overpayments will be applied as a credit to your account.

Financial Policy
I understand and agree that I am ultimately responsible and liable for payment of all charges assessed for professional services rendered and will pay any sum due upon demand. I understand that insurance claim forms will be submitted to my insurance company as a matter of convenience. I understand and agree that if it becomes necessary to retain an attorney and/or collection agency for the collection of any outstanding charges, whether or not a lawsuit is filed on my account, I will be responsible for any attorney and/or collection fees and court costs in addition to the outstanding balance.

I agree to the terms of the payment and cancellation policy. My signature on a facsimile copy, scanned copy, pdf file, or other reproduction of this document shall be as valid and binding as a signed original.

Signature______________________________________ Date _________________________

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of Piller Child Development's Notice of Privacy Practices.

________________________________ ____________________

Parent or legal guardian signature Date

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Printed Name if signed on behalf of the patient Relationship (parent, legal guardian, personal Representative, etc.)

I authorize and agree that Piller Child Development may disclose my protected health information to the following persons, each of who is directly involved in my care: (Please list pcp, and other doctors or therapists that you would like to receive copies of reports)

Name	Relationship to Child	Phone

I acknowledge and agree that Piller Child Development may disclose my protected health information to the persons set forth in this form unless and until I object to such disclosures, which must be provided in writing to Piller Child Development.

Piller Child Development may contact me via the following manners:

Phone ☐ yes ☐ no Leave Message ☐ yes ☐ no
Text Message ☐ yes ☐ no
Email ☐ yes ☐ no

________________________________ ____________________

Signature Date

____

Printed Name

My signature on a facsimile copy, scanned copy, pdf file, or other reproduction of this document shall be as valid and binding as a signed original.