

**McKenzie Pediatrics**  
**Patient Information**  
(please print)

Date: \_\_\_\_\_

Acct # \_\_\_\_\_

Child's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
(First) (Middle) (Last)

Soc. Sec # \_\_\_\_\_ Male  Female  Home Phone \_\_\_\_\_  
Cell/Pager: \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

If Patient Is A Student, Please Give Name of School: \_\_\_\_\_

RESPONSIBLE PARTY: (Name of person or person's responsible for this account.)

Parent  Guardian  Foster Parent

Mother's Name: \_\_\_\_\_ Employer: \_\_\_\_\_  
(First) (Last)

Birthdate: \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_ Work Phone: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Employer: \_\_\_\_\_  
(First) (Last)

Birthdate: \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_ Work Phone: \_\_\_\_\_

Check Appropriate Status:  Single  Married  Divorced  Separated  Widowed

Whom May We Thank For Referring You To Us? \_\_\_\_\_

Person To Contact In Case Of Emergency: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Friend  Relative

I authorize the following people to bring \_\_\_\_\_ in for treatment:

	Child's Name	
_____	_____	_____
Name	Relationship To Child	Phone / Cell

**INSURANCE INFORMATION:**

Name of Insurance/Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Please provide a copy of your current insurance card.

\*\*\*OVER FOR SIGNATURE \*\*\*

# McKenzie Pediatrics, PC.

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## Office Policy

Our office policies represent our constant attempt to maintain fairness to each and every one of our patient families.

**All Lane OHP and Omap Identification / Eligibility forms are required at “time of service”. If you do not present this form you may be asked to re-scheduled the appointment.**

Please give us 24-hour notice of any cancellation, to allow for other patients to be scheduled in that appointment slot. A cancellation at the time of the appointment is considered by us as a “No Show” since we cannot use the time to see another patient in your place. Once 2 appointments have been “No-Showed”, you will receive a warning letter. After a 3<sup>rd</sup> “No-Show” appointment you may be terminated from McKenzie Pediatrics and asked to find another physician.

Please remember that we care for many children at our office, and we strive to treat each child and family with equal consideration and respect.

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## Credit Policy

Co-payments if required by your insurance are due at time of service. Federal law requires that we not waive any patient co-payment, regardless of ability to pay, as this can be a form of discrimination.

We realize there are many families in a state of change. Our policy is that the parent or caregiver who requests treatment and brings the child in, will be responsible for payment (co-payment due at time service included) of services rendered.

Full payment is expected within 30 days of the service rendered unless otherwise arranged. If you are unable to pay your commitment within the 30 days of services rendered, please discuss this with our office staff to set up regular monthly payment arrangements. We do reserve the right to impose a 1.5% service charge (or 18% annual rate) on any balance outstanding more than 90 days past service rendered. After 90 days, if you have not made specific payment arrangements, or have not made any payments, necessary collection proceedings will be initiated. Maximum credit limit is \$500.

I consent to treatment. I authorize release of any information concerning my child's health care advice for the purpose of evaluating and administering claims for insurance benefits. I hereby authorize payment of insurance benefits payable direct to McKenzie Pediatrics, PC. Or Direct to the Physician.

I have read the above Office/Credit Policy, and agree to abide by its principles. I have been advised and or offered a copy of the Privacy Policy.

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Signature of Responsible party required: Parent/Guardian)

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Today's Date