

WILLIAM P. HITCHCOCK, M.D. A.P.C.

PATIENT INFORMATION (please do not use nicknames)

CHILD #1 Account #: _____ (office use only)
First name: _____ Middle: _____ Last: _____
Date of birth: _____ Sex: M / F

CHILD #2 Account #: _____ (office use only)
First name: _____ Middle: _____ Last: _____
Date of birth: _____ Sex: M / F

CHILD #3 Account #: _____ (office use only)
First name: _____ Middle: _____ Last: _____
Date of birth: _____ Sex: M / F

PATIENT ADDRESS: (NO P.O. BOX)

City: _____ State: _____ Zip: _____ Phone () _____

Father 1st name _____ MI: _____ Last: _____ Date of Birth: _____
home phone # _____ cell phone # _____
social security number _____ E-mail: _____

Mother 1st name _____ MI: _____ Last: _____ Date of Birth: _____
home phone # _____ cell phone # _____
social security number _____ E-mail: _____

BILLING ADDRESS:

City _____ State: _____ Zip _____

INSURANCE INFORMATION

Name of Insurance: _____ Policy Holder: _____

EMERGENCY INFORMATION - Someone not living in household

Name: _____ Relationship: _____ Phone: () _____

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POLICIES

1. As a courtesy to you, we will bill your insurance for services rendered if we are a provider under your insurance plan.
2. Parents / Guardians are responsible for payment regardless of their insurance situation.
3. Co-payments are due at time of service.
4. You are responsible for payment of services that are not covered by your insurance.
5. Patients with unsatisfied deductibles are required to pay in full at the time of service, or make financial arrangements with the billing department.
6. There is a \$25.00 bank service charge for returned checks.
7. There is a \$30.00 charge for missed appointments, or appointments not canceled within 4 hours or your scheduled appointment time.
8. There will be a \$10.00 charge for re-writing an immunization record, triplicate prescription and / or various required forms.
9. It is your responsibility to inform the office of any changes of address, phone numbers or insurances.

RELEASE OF AUTHORIZATION / ASSIGNMENT OF BENEFITS

I authorize the release of any medical information necessary to process my insurance claims. I authorize and request payment of medical benefits be made directly to William P. Hitchcock, M.D. I agree that a photocopy of this form may be used in place of the original.

I have read and understand the above policies and release of authorization.
I have verified that the patient information is accurate..

X _____
Signature of Parent or Guardian

_____/_____/_____
Date