2530 Ridge Ave Ste. 201 Evanston IL. 60201 Telephone: (847)869-0892 Fax: (847)869-1070

Insurance Guarantor Information

First Name	Middle Name	Last Name	
Date of Birth	Marital Status ( )single ( )married ( )divorced		
Address	City	State	Zip
Name of Insurance	Effective Date:	Group#	ID#
Home Phone ( )	Work Phone ( )	Cell Phone ( )	Email

Other Parent Information

First Name	Middle Name	Last Name	
Date of Birth	Marital Status ( )single ( )married ( )divorced		
Address	City	State	Zip
Home Phone ( )	Work Phone ( )	Cell Phone ( )	Email

Preferred Language

English	Spanish	Arabic	Chinese	Polish	Other	Decline to Specify

Ethnicity

Hispanic/Latino		Non-Hispanic/Latino		Decline to specify	

Race

White	Black	American Indian/Alaska Native	Asian	Native Hawaiian/Other Pacific Islander	Other Race	Decline to Specify

Referred by	

Children

Name	Date of Birth	M	F
Name	Date of Birth	M	F
Name	Date of Birth	M	F
Name	Date of Birth	M	F
Name	Date of Birth	M	F

northsuburban
PEDIATRICS

Financial Policy

North Suburban Pediatrics is a contracted with many different insurance plans. It is the insured's responsibility to check with their insurance plan for policy provisions and to see if their doctor is contracted with the plan. Please be advised that all services are billed according to the medical care that was provided, not to what is covered by your insurance plan. The office will bill your insurance as a courtesy to you, however, any claims not paid after 60 days become your responsibility to dispute with your insurance company.

ALL COPAYS ARE DUE AT TIME OF SERVICE.

In accordance with our signed contracts with the insurance carriers, we are responsible for collecting these copays; they cannot be billed to you, co-pays will be added to well physicals if significant health problems or chronic conditions are addressed during the visit. All balances after insurance pays are due within 30 days of receiving your statement. All financial questions or disputes are to be referred to the Billing Department

Starting January 1st, 2018 a $25 fee will be charged for all missed appointments that are not cancelled by 10am on the day of the appointment.

Patient Signature_____ Date_____

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PEDIATRICS

Family Account # _____

Sunday and Holiday

I understand that there is a $40.00 fee for Sunday and Holidays that must be paid at the time of service along with our original co-pay.

Signature _____Relationship_____

Assignment of Insurance Benefits/Payment Guarantee/Collection fee

I hereby authorize payment to be made directly to North Suburban Pediatrics for insurance benefits payable to me. I understand that I am financially responsible to North Suburban Pediatrics for any covered or non-covered, as defined by my insurer, which are not paid by my primary insurer. I also understand that if my account balance becomes overdue and the overdue account is referred to a collection agency, a collection fee, not to exceed 25% of the overdue balance, may be added to the amount due and that I am financially responsible for the added collection fee and any reasonable attorney

Signature of Policy Holder _____ Date _____

HIPAA Notice of Privacy Practices

Acknowledgement

I have received a copy of North Suburban Pediatrics, S.C's HIPPA Notice of private practices.

_____

Patient Signature

_____

Date