Patient Name (first, middle, last): _____

DOB: _____ SSN: _____ Race/Ethnicity:_____ Gender:_____

Preferred Phone: _____ Other Phone:_____

Home Address: _____

Email: _____

Primary Insurance Company: _____

Secondary Insurance Company: _____

Guarantor Name: _____

Guarantor DOB: _____ Guarantor SSN: _____

Relationship to patient: _____

Emergency Contact:_____

For Siblings with same Insurance/Guarantor please list Name, DOB:

_____

_____

Guarantor Payment Responsibilities

Parkway Pediatrics, LLC has contracted a billing service company, *Southeast Physician Services,* to handle all our claims. We are required to **collect your co-pay at the time of service** as this will be reported to your insurance company. Self-pay families will be encouraged to pay their bills in full at the time of service to receive a 20% discount.

Should your insurance company reject our claim for payment; the responsibility for full payment will be transferred to the guarantor on our files.

Thank you for your cooperation. We appreciate your loyalty.

_____ _____

Guarantor signature Date Witnessed by Parkway Pediatrics Staff Date