

THE PEDIATRIC CENTER

Franklin Park

3740 W. Sylvania Ave.
Suite 250
Toledo, OH 43623
419-473-6670
Fax 419-473-9959

Oregon

3156 Dustin Rd.
Suite 300
Oregon, OH 43616
419-697-6777
Fax 419-697-6712

Lambertville

3309 Quail Hollow
Suite C
Lambertville, MI 48144
734-854-2428
Fax 734-854-2237

Adrian

770 Riverside Ave.
Suite 17
Adrian, MI 49221
517-265-8134
Fax 517-265-2249

FINANCIAL INFORMATION

Children's names, Birth Dates and Sex

Parent/ Guardian responsible for bill:

Address

Street _____ City _____ State _____ Zip _____

Phone

Home with area code _____ Business with area code _____

Fill in the following insurance and give us your insurance card to copy

PARENT INFORMATION

PRIMARY INSURANCE

Insurance Company

Insurance Claim Mailing Address

Contract Number

Group Number

PARENT Name

PARENT SS Number

PARENT Date of Birth

Policy Holder's Employer

SECONDARY INSURANCE

I hereby authorize the release of information by Pediatric Center, Inc. concerning my child/ children's medical condition to my insurance carrier that requires information regarding for evaluating disability, hospitalization, laboratory testing or other insurance status.

I also authorize payment directly to Pediatric Center Inc. of the medical benefits, if any, otherwise payable to me for these services as described, but not to exceed this reasonable and customary charges for these services.

FINANCIAL INFORMATION

The following are guidelines for our financial policy:

- I agree to pay all patient responsible balances promptly
- I agree to pay at time of service for services rendered if my coverage is non HMO or PPO
- I agree not to exceed a patient due credit limit of \$150.00
- I understand that 1.5% interest is added on patient due balances over 30 days
- I understand that in cases of legal separation or divorce, if my account balance becomes delinquent, that I am financially responsible for this amount since I am the parent who brings the child in for care

Signature of Patient, Parent or Guardian

Date