Sunrise Pediatrics

SunrisePediatricsLasVegas.com

Maryland Office: (702) 254-KIDS (5437)

Rainbow Office: (702) 361-KIDS (5437)

Smoke Ranch Office: (702) 820-KIDS (5437)

GENERAL INFORMATION **ANNUAL UPDATE**

Patient Name:_____
First Middle Last

Date of Birth: _____/_____/_____ Age: _____ Gender: M / F

Mother's Name: _____

Father's Name: _____

Primary Address: _____Apt #_____

City: _____ State:_____ Zip:_____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Other: _____

Email Address: _____

Preferred Language: _____

PRIMARY INSURANCE INFORMATION

Name of Insured: _____ DOB: ____/___/_____

Relationship to Patient: Self Mother Father Other: _____

Insurance Company: _____

Policy Number:_____ Group #:_____

Employer: _____

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SECONDARY INSURANCE INFORMATION

Name of Insured: _____ DOB: ____/___/_____

Relationship to Patient: Self Mother Father Other: _____

Insurance Company: _____

Policy Number:_____ Group #:_____

Employer: _____

EMERGENCY CONTACT

Name: _____ Phone #: _____

PHARMACY

Preferred Pharmacy: _____

Pharmacy phone #: _____

Pharmacy Address or Cross Streets: _____

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_____ _____
Print Patient Representative Name Relationship to Patient

RECEIPT OF ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I hereby acknowledge that I was offered to read or take with me a copy of the Privacy Policy issued by Sunrise Pediatrics, on the date indicated below. I understand that I may ask for a copy at any time.

To respect your privacy please tell us how we may contact you:

Home/ Cell Phone:

- ❑ You may leave a message with the following person(s) if I am not available:
  _____
- ❑ You may leave DETAILED INFORMATION on my voicemail.
- ❑ You may leave your NAME and PHONE NUMBER ONLY on my voicemail and I will return your call.

Work Phone:

- ❑ You may call my work place.
- ❑ You may leave DETAILED INFORMATION on my work voicemail.
- ❑ You may leave your NAME and PHONE NUMBER ONLY on my work voicemail and I will return your call.
- ❑ You may NOT call my workplace.

Please list parents, family, friends, caretaker, etc. that we may communicate with in regards to your child's personal medical and financial information. This will include but is not limited to: test results, appointment dates and times, and billing information. Only the names that are listed below will be able to receive your information. Do not include your physicians on this list.

1. _____ Phone: _____
2. _____ Phone: _____
3. _____ Phone: _____
4. _____ Phone: _____

Unless you notify us in writing stating otherwise the above person(s) will always be able to receive information about you.

_____ _____
Patient's Signature Date

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REQUEST FOR TREATMENT AND INSURANCE VERIFICATION

This is to certify that I, _____authorize Sunrise Pediatrics to file claims to my insurance company(s) for services rendered to me by Dr. Sanjay Kandoth or any of his medical providers. I certify that the information I have reported with regard to my insurance company is correct and understand that I am responsible to notify Sunrise Pediatrics if my insurance company changes, benefits are terminated or if the coverage I have reported is incorrect. I understand and agree that it is my responsibility to understand the benefits of my insurance plan and that failing to do so may result in lesser payment or no payment at all from my insurance carrier(s). I understand and agree that I am ultimately responsible for payments in full for all services that I have received from Sunrise Pediatrics.

If a referral is required, I understand that it is MY responsibility to obtain all documentation required by any insurance carrier or reimbursing agent in order to determine payable benefits.

_____ Parent/Guardian Initials

PAYMENT AT TIME SERVICES ARE RENDERED

I understand that payment of the Estimated Bill will be made at the times services are rendered. I understand that my Estimated Bill will be provided prior to leaving the office and will detail my expected out-of-pocket charges based on Sunrise Pediatrics' contractual fee schedule with my insurer and the details of my particular insurance plan. The Estimated Bill will detail all deductible, copay, and coinsurance expected to be owed by me to Sunrise Pediatrics. It is anticipated that my Explanation of Benefits will detail these charges after submission of my claim. My estimated payment could potentially result in an under-payment or overpayment based on my insurance carrier's determination of the filed claim. If an under-payment occurs, I understand that I will be billed for the remainder owed. Sunrise Pediatrics will issue a prompt refund for any overpayment that is made by me.

_____ Parent/Guardian Initials

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FINANCIAL POLICY

Sunrise Pediatrics, is dedicated to providing our patients with the best possible care. We ask your help by understanding and cooperation with our financial policy. We must emphasize that as physicians, our relationship is with you, NOT your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are strictly your responsibility. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

INSURANCES: We participate with many insurance companies. Please check with office staff to see if we participate with your insurance plan. If we DO participate with your insurance company, all services performed in our office will be submitted, unless we have received prior notification of non-covered services. All co-pays, deductibles and coinsurance amounts are your responsibility and due at the time of service.

CO-PAYS AND OUTSTANDING BALANCES:
All copays are due at the time of service. All outstanding balances on accounts are due at the time of service.

DISABILITY AND OTHER INSURANCE FORM COMPLETION:
Our office will complete your disability or other insurance claim forms. The fee for each form is $15 and must be paid in advance prior to completion of your form. PLEASE ALLOW 7-10 Business days for completion of your disability forms.

CHECKS RETURNED FOR INSUFFICIENT FUNDS:
If we receive a returned check for insufficient funds, we will immediately reverse the payment on your account and will also charge a $25 fee to your account.

COLLECTION ACCOUNTS:
Our office will make every effort to communicate with you about your account and will present reasonable options for payment. In the event a bill goes unpaid without contacting the billing department to discuss payment options, the account will be turned over to collections. If your account is sent to our collection agency, a collection charge of 30% of the amount due may be added to the balance of your account. In the event your account is turned over to an attorney you will be responsible for any and all attorney fees plus court costs.

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SELF-PAY POLICY:
Payment is expected at the time of service. Prompt pay discounts may be available, please check with billing staff for details.

I HAVE READ AND FULLY UNDERSTAND THE FINANCIAL POLICY SET FORTH BY SUNRISE PEDIATRICS, AND I AGREE TO THE TERMS OF THIS FINANCIAL POLICY. I ALSO UNDERSTAND AND AGREE THAT THE TERMS OF THE FINANCIAL POLICY MAY BE AMENDED BY THE PRACTICE AT ANY TIME WITHOUT PRIOR NOTIFICATION TO THE PATIENT.

_____ _____

Signature of Patient/Guardian Date