



3555 Willow Lake Blvd Suite 140 Vadnais Heights MN 55110
14712 Victor Hugo Blvd Suite 40 Hugo MN 55038

PATIENT INFORMATION

NAME LAST FIRST MI SEX M F BIRTHDATE
SOCIAL SECURITY # HOME PHONE CHILD'S CELL PHONE
STREET CITY ST ZIP

PARENT/GUARDIAN INFORMATION

FATHER BIRTHDATE
PARENT STEP PARENT GRANDPARENT LEGAL GUARDIAN OTHER
STREET CITY ST ZIP
SOCIAL SECURITY # HOME PHONE CELL PHONE
EMPLOYER POSITION WORK PHONE

MOTHER BIRTHDATE
PARENT STEP PARENT GRANDPARENT LEGAL GUARDIAN OTHER

Your Maiden Name

STREET CITY ST ZIP
SOCIAL SECURITY # HOME PHONE CELL PHONE
EMPLOYER POSITION WORK PHONE

RESPONSIBLE PARTY (BILLING INFORMATION)

NAME PARENT STEP PARENT GRANDPARENT LEGAL GUARDIAN OTHER
STREET CITY ST ZIP
HOME PHONE WORK PHONE CELL PHONE

EMERGENCY CONTACT

Someone not in your house -

NAME Relationship Phone Number

OTHER CHILDREN LIVING AT YOUR HOME

Blank lines for other children living at home

Above information is still current/correct: Init Date Init Date Init Date

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OFFICE USE
TODAY'S DATE CHART LOCATION BUS OFC CK'D

TURN TO BACK

**FINANCIAL/CREDIT INFORMATION**

In compliance with the Federal Consumer Protection Act, Northern Lights Pediatric & Adolescent Medicine wishes to notify you of its policies regarding the financial responsibilities associated with services rendered to you or a member of your family.

- We will furnish you with a monthly statement of your account showing both the amounts billed to you and the payments or credits to your account. The monthly bill will also provide you with a detailed aging of how long the balances have been outstanding.
- We are legally required to submit a bill to your insurance company that includes all the services you received at a visit. If we need to treat a condition or order additional testing/labs at the physical, your bill will show services for the physical and the problem-related exam and labs separately. You may consider the appointment as one visit, but your insurance company may not and you could be billed for this or need to make a copayment.
- We require the patient/parent to be responsible for providing current insurance as we do file many types of insurance forms for our patients. You must verify we are your child’s primary care clinic (PCP) if your plan requires you to select one. Please talk to our business office staff to determine your specific responsibilities in this area.
- Payment for services rendered is considered due and payable at the time you receive service. Extended payment programs are available to you if arranged and approved by our business office.
- All personal payments will be applied to today’s copay or the oldest charge first.
- Copayments assigned by your insurance company are due at time of service. Any copayments as designated by the HMO/PPO plan that are not paid at the time of service may accrue an additional five dollar (\$5.00) surcharge.

The undersigned hereby acknowledges to have read and agrees to the above financial credit and payment policies of Northern Lights Pediatric & Adolescent Medicine.

Signed \_\_\_\_\_ Date \_\_\_\_\_  
 \_\_\_\_\_ Init \_\_\_\_\_ Date \_\_\_\_\_  
 \_\_\_\_\_ Init \_\_\_\_\_ Date \_\_\_\_\_

**ASSIGNMENT OF BENEFITS**

I hereby authorized payment of medical benefits due to me under the terms of my policy to Northern Lights Pediatric & Adolescent Medicine. I understand the clinic’s charge may exceed the insurance company/Medicaid payment, and if greater than such, I will be responsible for paying that additional allowable amount. I also understand that if my insurance plan requires a referral authorization for my appointments, it is my responsibility to obtain a referral prior to the appointment. I will be responsible for the unpaid balance due any bills if this is not done.

Signed \_\_\_\_\_ Date \_\_\_\_\_  
 \_\_\_\_\_ Init \_\_\_\_\_ Date \_\_\_\_\_  
 \_\_\_\_\_ Init \_\_\_\_\_ Date \_\_\_\_\_

**RELEASE OF INFORMATION**

I hereby authorize Northern Lights Pediatric & Adolescent Medicine to furnish information regarding my child’s health care and medical history to insurance carriers and to other medical care providers to whom I might be referred by Northern Lights Pediatric & Adolescent Medicine and to furnish any information necessary to complete any health form I might submit on behalf of my child’s school, camp, athletic organization or the like.

Signed \_\_\_\_\_ Date \_\_\_\_\_  
 \_\_\_\_\_ Init \_\_\_\_\_ Date \_\_\_\_\_  
 \_\_\_\_\_ Init \_\_\_\_\_ Date \_\_\_\_\_

**INSURANCE INFORMATION – Have your insurance card copied**

Name of Insurance Company \_\_\_\_\_ Eff Date \_\_\_\_\_

Address of Insurance Company \_\_\_\_\_

Policy or ID # \_\_\_\_\_ Group # \_\_\_\_\_

Policy Holder Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Secondary Insurance Company \_\_\_\_\_ Eff Date \_\_\_\_\_

Policy Holder Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Policy or ID# \_\_\_\_\_ Group # \_\_\_\_\_