For the following insurances, please fill this form:

AETNA

AMERIGROUP

ANTHEM BCBS

CAREFIRST BCBS

CIGNA

CORESOURCE

COVENTRY HEALTH

GEHA

GOLDEN RULE

GREAT WEST

GUARDIAN LIFE INSURANCE

MD MEDICAL ASSISTANCE

MAMSI

Maryland Physicians Care

MEDICARE

NCAS

NCPPO

ONE NET PPO LLC

PHCS

PRINCIPAL LIFE INSURANCE

PRIORITY PARTNERS

TRICARE

UNITED HEALTH CARE PPO, Choice Plus options

UNICARE

UMR

Welcome!

Primary Care Provider (PCP) Selection / Insurance Selection:

If you are enrolled in an insurance plan that requires you to select PCP and you would like us to be your primary provider. It is your responsibility to make sure that you have selected us. We will not be able to see you for an office visit if we are not your primary provider. If you have questions, please ask the receptionist. It is your responsibility to know your insurance policy benefits.

Forms:

To complete any forms such as (school, athletic, work daycare, foster, etc.). You need to schedule an appointment with any primary care physician.

Payment:

For your convenience we accept Visa, MasterCard and personal checks. We don't accept American Express and Discovery. Please note there is a $35.00 fee for returned checks.

Co-Payment:

Your co-pay is due in full before you see the doctor. We do not bill for co-payments.

Self-Pay:

Patients without health insurance are expected to pay in full at the time of service. You may pay with cash, credit card, debit card, checks or money order.

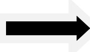
Appointments:

We require a 24-hour notice for all appointment cancelation.

Late Arrival:

If you are more than 15 minutes late for your appointment, you will be considered as a walk-in. At the discretion of management you may be worked into the schedule with no guarantee of when you will be seen.

We **THANK YOU** for choosing Med-Ped Health Care, LLC to provide you with comprehensive medical care; we would like to ensure and provide professional care. Please leave us with a phone number you can be reached at, both day and night if you wish.



____________________________________	________________________
Patient or parent legal guardian signature	Date

Personal and Insurance Information

Patient Information:

Last name: ______________________ First name: __________________________ Mi_______

Address: ____

City: __________________________ State: _________ Zip code: __________

Sex (M/F):__________ Status: ____Single ____Married ____Divorce ____Widow

Date of Birth: _____/_____/________ Social Security: ______/_____/_________

Email: ____

Home Phone: ______/_______/__________ **Cell Phone:** _______/_______/_____________

Employer: ________________________________ **Work Phone**: _______/_______/____________

Emergency Contact: _______________________________ Emergency Phone: ______/_______/________

Primary Insurance Coverage:

Company: ___________________________

Insured name: __________________________

Relationship: ___________ DOB: __________

Co-pay amount: ________________________

Policy number: _________________________

Group number: _________________________

Secondary Insurance Coverage:

Company: ______________________________

Insurance name: _______________________________

Relationship: _______________DOB: _____________

Co-pay amount: _______________________________

Policy number: ________________________________

Group number: ________________________________

Guarantor Information:

Guarantor: _______________________________________ Relationship to patient: ___________________

Address: ____City: ________________ Zip: ____________

Sex (M/F):__________ Date of Birth: _____/_____/________

Home Phone: ______/_______/__________ Cell Phone: _______/_______/_____________

Employer: _________________________________Work Phone: _______/_______/_____________

Patient Health History Questionnaire

Do you have any allergies or have you had any reactions to any medicines? Yes___ No____

Please list medicines and reactions: ____

____

Do you have a living will? Yes____ No____

Please list all medicines you are currently taking:

Name of Medicine	Amount (Dose)	How long?	Doctor's name	For what reason

Immunization Status:

Have you had the influenza or pneumovax vaccine? Yes____ No____

When was your last tetanus vaccine/booster? ____________________________

Other vaccines? If so, what vaccine and when? ___________________________

Medical History Review:

Have you had or do you currently have:		Do you have a family history of:	Relationship
Have ___ Had ___ Never ___	Diabetes (sugar)	Yes ___ No ___	___________
Have ___ Had ___ Never ___	Glaucoma	Yes ___ No___	___________
Have ___ Had ___ Never ___	Bleeding Disorder/ blood disease	Yes ___ No___	___________
Have ___ Had ___ Never ___	Asthma/ Hay fever	Yes ___ No ___	___________
Have ___ Had ___ Never ___	High Blood Pressure/ stroke	Yes ___ No___	___________
Have ___ Had ___ Never ___	Heart attacks/ chest pain	Yes ___ No___	___________
Have ___ Had ___ Never ___	Seizures, convulsions, blackouts	Yes___ No___	___________
Have ___ Had ___ Never ___	Depression, suicide, mental illness	Yes___ No___	___________
Have ___ Had ___ Never ___	Cancer: Type_______________	Yes___ No___	___________
Have ___ Had ___ Never ___	Ulcers, Stomach or intestinal bleeding		
Have ___ Had ___ Never ___	Weight problem: Over___ Under___		
Have ___ Had ___ Never ___	Heart murmur/ Rheumatic fever		
Have ___ Had ___ Never ___	Treatment with cortisone		
Have ___ Had ___ Never ___	Angry, emotional or abusive exchange with your spouse?		
Have ___ Had ___ Never ___	Children with special problems or difficulty getting along With family or friends?		

Do you have family history of: Drug abuse Yes____ No ____

Alcoholism Yes ___ No ____

Authorization For Claims Payment and Reviews

1. **Assignment and Coordination of Insurance Benefits:** I authorize Med-Ped Health Care, LLC, to apply benefits on my behalf for services rendered by Med-Ped Health Care, LLC. I also agree to provide information regarding all group hospitalization, health maintenance organization, Workers' Compensation, automobile, and other health care benefits ("Insurance Plan(s)") to which I may be entitled. I hereby assign payment(s), if any, from my Insurance Plan(s) to Med-Ped Health Care, LLC (or its affiliate) and each of the independent contractor physicians and/or professional corporations for services rendered to me. The direct payment hereby assigned and authorized includes any Insurance Plan(s) benefits to which I am otherwise entitled, including any major medical benefits otherwise payable to me under the terms of my policy, but is not to exceed the balance due to the Med-Ped Health Care, LLC (or its affiliate), the independent contractor physicians and/or professional corporations for services rendered to me during the applicable periods of medical care.

2. **Unauthorized, Non-Covered, or Out of Plan Services:** I understand if my Insurance Plan(s) does not consider any service rendered during the visit covered service or has not authorized this service, they will not pay for this visit or the service rendered during this visit or any service if determined by my Insurance Plan(s) to be a non-covered service. I also understand and acknowledge that in the case of Out of Plan/Network services, there may be reduced benefits and I may be required to pay a larger co-payment, deductible, co-insurance or other charge. In the event my Insurance Plan(s) does not reimburse these services provided to me, I acknowledge I will be responsible for any remaining balance.

3. **For Medicare Recipients Only**: I request that payment of authorized Medicare benefits be made on behalf to Med-Ped Health Care, LLC for any services furnished to me by that physician. I authorize any holder of medical information about me to release to the Center for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for the related services. In the case of Medicare Part B benefits, I request payment either to myself or to the party who accepts assignment.

By signing below, I certify I have read and understand the foregoing, have had the opportunity to ask questions and have them answered and accept the above conditions and terms and I agree to pay all charges for which I may be legally responsible including, but not limited to health insurance deductibles, co-payments, and non-covered services. I also agree in the event my account must be placed with a collection agency to obtain payment, I will pay the reasonable collection costs of 45% incurred by Med-Ped Health Care. I understand and agree this document will remain in effect for all future outpatient or physician visits to Med-Ped unless specifically rescinded in writing by me.

Patient Signature: ___________________________________ Date: _______________

Patient Name: _____________________________________

If Representative, Print Name and Relationship to Patient:

____

How did you hear about Med-Ped Health Care?

Internet

☐ Web Search (Google, Bing, Yahoo, etc.)

Keywords used in search: ____________________________________

☐ Location-Based Services (Foursquare, Yelp, Google Maps, etc.)

☐ Online Advertising (Diamondback, UMD apps, YP.com, etc.)

☐ Social Media (Twitter, Facebook, YouTube, Pinterest, etc.)

☐ www.ZocDoc.com

Word Of Mouth

☐ Family Member

☐ Friend

☐ Referral by Dr. __________________________

Others:

☐ Outdoor Signage

☐ __________________________ Insurance Company

☐ __________________________ Hospital

☐ Other than all above, please write below:

____