RIVIERA PEDIATRICS

4115 Office Plaza Blvd.
Indianapolis, IN 46254
317-297-3507

Doctor_____

Appointment Date_____ Appointment Time_____ Today's Date:_____

Patient's Name:_____ Sex:_____ DOB:_____/_____/_____

Patient's Name:_____ Sex:_____ DOB:_____/_____/_____

Patient's Name:_____ Sex:_____ DOB:_____/_____/_____

Patient's Name:_____ Sex:_____ DOB:_____/_____/_____

Patient's Name:_____ Sex:_____ DOB:_____/_____/_____

Address:_____ _____

City:_____ State:_____ Zip:_____

Home Phone:_____-_____-_____ Mother's Cell #_____-_____-_____

Father's Cell #_____-_____-_____

Mother's Full Name:_____

Mother's SS#_____--_____--_____ Mother's DOB:_____/_____/_____

Mother's DLN_____ Expiration_____

Mother's Employer:_____ Work Phone #_____

Father's Full Name:_____

Father's SS#_____--_____--_____ Father's DOB:_____/_____/_____

Father's DLN_____ Expiration_____

Father's Employer:_____ Work Phone #_____

Responsible Party's Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Home Phone #_____--_____--_____ Cell #_____--_____--_____

_____ _____

Signature of Responsible Party or Patient if over the age of 18 Date

Insurance Form

PRIMARY INSURANCE **- We require a copy of your current insurance card**

Insurance Company: _____
(on back of card)

Ins. Company's Address: _____

City: _____ State: _____ Zip: _____

Policy Holder's Name: _____

Policy Holder's SS#: _____--_____--_____ Policy Holder's DOB: _____/_____/_____

Policy Holder's Employer: _____

Issue Date: _____/_____/_____ End Date: _____/_____/_____ Co-Pay Amount $_____

I.D.#: _____ Group #: _____

SECONDARY INSURANCE **- Riviera Pediatrics will only file with the following secondary insurance companies: Anthem/Blue Cross Blue Shield, Children's Special Health Care, Medicaid and United Healthcare. Other secondary insurance will have to be filed by the policy holder.**

Insurance Company: _____
(on back of card)

Ins. Company's Address: _____

City: _____ State: _____ Zip: _____

Policy Holder's Name: _____

Policy Holder's SS#: _____--_____--_____ Policy Holder's DOB: _____/_____/_____

Policy Holder's Employer: _____

Issue Date: _____/_____/_____ End Date: _____/_____/_____ Co-Pay Amount $_____

I.D.#: _____ Group #: _____

I request that payment of authorized benefits be made on my behalf for any services furnished to me by Riviera Pediatrics including the physicians' services. I authorize any holder of medical or other information about me to release to the healthcare financing administration, its agents or other health carriers the information as needed to determine these benefits for related services.

Signature of Responsible Party: _____ Date:_____

Revised 6/6/12

Patient Name: _____ **Account #** _____

RIVIERA PEDIATRICS
Financial Payment Policy

Thank you for choosing Riviera Pediatrics as your child's primary care provider. Please read this payment policy and sign it in the space provided. We will provide a copy for your own records.

1. Insurance Billing. We participate in most insurance plans, including Medicaid. As a courtesy to you, we will file your claims to your insurance company. Remember, most secondary insurance claims are your responsibility to file. However, it is your responsibility to understand what services are covered under your medical insurance policy. If you have any questions whether a service is covered, we urge you to contact your insurance company before the service is provided. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Please contact your insurance company with any questions you may have regarding your coverage.

2. Medicaid. As per Indiana State Law, you are required to see the physician your child has been assigned to by Medicaid. You will be responsible for the balance if your child is ineligible for Medicaid benefits through our practice. We look forward to treating your child once you've been re-assigned to one of our doctors.

3. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. At the time of check-in, each parent/guardian will be asked to make this payment. Because this is an insurance requirement, we cannot bill you for these.

4. Non-covered services. Please be aware that some and perhaps all of the services you receive may not be covered by your insurance. You must pay for these services **in full** at the time of your office visit.

5. Proof of insurance. All parents/guardians must complete our patient information form before seeing the doctor. **It is your responsibility to provide us with the correct and current insurance card.** If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

6. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly to them. It is your responsibility to comply with their request. If the claim is denied and/or remains unpaid, the balance on your account is your responsibility. After your claim has been filed and paid by your insurance company, you will be billed for the remainder of any balance. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

7. Coverage changes. If your insurance changes, it is your responsibility to notify us before your next visit so we can correctly file your claims to help you receive your maximum benefits. If not, you may incur further charges because of claims being filed to the wrong company.

8. Nonpayment. If your account is past due, you will receive a letter stating that you have 7 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated with a payment plan. Please be aware that if a balance remains unpaid, we may refer your account to an attorney and be taken to small claims court. We could proceed with wages being garnished at that time. If your account becomes outstanding, you will be responsible for all costs of collection including, but not limited to filing fees, reasonable attorney fees, interest on any judgment obtained, and other like costs.

9. Transferring of Records. You will need to request in writing, and pay a $20.00 copying and service fee if you want to have copies of your records sent to another doctor or organization. The fee is $20.00 per child for the first 10 pages plus $.50 per page for pages 11-50 and $.25 per page for pages 51 and up. You must authorize us to release this information.

10. Returned checks. There is a $25 fee for any checks returned by the bank.

Note to divorced parents of dependents. Both parents are responsible for the dependent's fees. We will send our statement to the address you have given us and the responsible party should make prompt payment upon receipt.

Please be sure to bring your **current insurance cards** with you at **every visit** so that we may properly bill your correct and current insurance carrier. Riviera Pediatrics is committed to providing the best treatment for our patients and we expect the same courtesy in return. By my signature below, I state that the above policy has been read and that I understand and agree to said policy.

Thank you for understanding our payment policy.

Signature:_____ Date:_____

Witness
Signature:_____ Date:_____

Revised 06/05/12