MEMPHIS CHILDREN'S CLINIC, PLLC

Today's Date _____

Child's Name _____ Nickname_____

Date of Birth _____ Sex_____ SSN_____

Primary Address _____

Who is the Primary Caretaker for this child? _____

Primary language spoken in the home _____

Mother's Name _____ Date of Birth_____

Address (if different from child) _____

Home Phone_____ Cell phone_____

Email Address_____SSN_____

Employer _____Employer Phone_____

Employer Address _____

Father's Name _____ Date of Birth_____

Address (if different from child) _____

Home Phone_____ Cell phone_____

Email Address_____SSN_____

Employer _____Employer Phone_____

Employer Address _____

Who is the child's Legal Guardian? Name _____ Date of Birth_____

Relationship to child_____ Address (if different from child) _____

Home Phone_____ Cell phone_____

Email Address _____

Emergency Contact (Please list someone not named already) Name_____ Relationship to child_____

Address (if different from child) _____

Home Phone_____ Cell phone_____

Email Address _____

INSURANCE INFORMATION

Primary Insurance Name _____ Co-Pay Amount _____

Policy Holder's Name _____

Policy Number_____ Group Number _____

INSURANCE INFORMATION

Secondary Insurance Name _____ Co-Pay Amount _____

Policy Holder's Name _____

Policy Number_____ Group Number _____

Please give our Receptionist your insurance card(s) to copy. We must have a copy of your cards to file your Insurance.
Due to insurance contact requirements, we collect the patient's portion at the time of service.

Please sign the back of this form.

Insurance Authorization & Benefit Assignment

I hereby authorize Memphis Children's Clinic to release all information necessary including Medical Records, to insurance carriers to secure payment for myself or my dependents. I hereby assign all medical and/or surgical benefits to which I am entitled, including private insurances, and any other health plans, to Memphis Children's Clinic, for services rendered to myself or to my dependents.

Patient/Guardian_____

Statement of Financial Responsibility

In the event that your account is placed with a Collection Agency, a collection-fee of up to 33.3% may be added to your account and shall become a part of the Total Amount Due. You will be responsible for any and all reasonable collection fees including collection fees, reasonable attorney fees and court cost.

You agree, that in order for us to service your account or to collect any amounts you may owe, we and our collection agencies may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We and our collection agencies may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artiftcial voice messages and/or use of an automatic dialing device, as applicable.

Guarantor_____ Date_____

Medicare - Medicaid Certification

I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare/Medicaid claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to Memphis Children's Clinic on any bills for services furnished me.

Patient/Guardian_____

Person Authorizing Treatment _____

Relationship to Patient _____