

# SPRINGBORO PEDIATRICS, INC.

**\*TO MAKE CHANGES SEE  
DIRECTIONS ON NEXT PAGE**

8 Sycamore Creek Drive  
Springboro, Ohio 45066  
Phone: 937 748-KIDS (5437)  
Fax: 937 748-5434

Acct# \_\_\_\_\_

Brian Esselstein, M.D.

Charles Hutchison, M.D.

Nalini Aggarwal, M.D.

## PATIENT INFORMATION (PLEASE PRINT)

Today's Date \_\_\_\_\_

Patient's Name \_\_\_\_\_ Birthdate \_\_\_\_\_  
First Middle Last

Address \_\_\_\_\_  
City State Zip

Home Phone# \_\_\_\_\_ Sex \_\_\_\_\_ SS# \_\_\_\_\_ Birth Place \_\_\_\_\_  
Area code Hospital

Father's Name \_\_\_\_\_ Mother's Name \_\_\_\_\_

### SECTION II

**PLEASE MAKE SURE ALL PATIENT INSURANCE INFORMATION IS ON THIS SHEET**

Responsible Parent or Guardian \_\_\_\_\_ Birthdate \_\_\_\_\_  
First Middle Last

Address \_\_\_\_\_ Home Phone# \_\_\_\_\_  
City State Zip Area code

Employer \_\_\_\_\_ Years Employed \_\_\_\_\_ Working Hours \_\_\_\_\_

Employer's Address \_\_\_\_\_ Business Phone \_\_\_\_\_  
Area code

Type of Insurance \_\_\_\_\_ Effective Date \_\_\_\_\_ Group# \_\_\_\_\_

Subscriber# \_\_\_\_\_ SS# \_\_\_\_\_ Plan# \_\_\_\_\_

Check which is the correct coverage for this patient under this insurance  Primary  Secondary  No Coverage

### SECTION III

Other Parent or Guardian \_\_\_\_\_ Birthdate \_\_\_\_\_  
First Middle Last

Address \_\_\_\_\_ Home Phone# \_\_\_\_\_  
City State Zip Area code

Employer \_\_\_\_\_ Years Employed \_\_\_\_\_ Working Hours \_\_\_\_\_

Employer's Address \_\_\_\_\_ Business Phone \_\_\_\_\_  
Area code

Type of Insurance \_\_\_\_\_ Effective date \_\_\_\_\_ Group# \_\_\_\_\_

Subscriber# \_\_\_\_\_ SS# \_\_\_\_\_ Plan# \_\_\_\_\_

Check which is the correct coverage for this patient under this insurance  Primary  Secondary  No Coverage

List any other adults LEGALLY responsible for the insurance, payment, or obtaining information on this child:

NAME	RELATIONSHIP	ADDRESS & PHONE#
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## PLEASE READ COMPLETELY

Patient's Name \_\_\_\_\_ Birthdate \_\_\_\_\_  
First Middle Last

### **ACKNOWLEDGEMENT FORM**

The Notice of Privacy Practices is located in the waiting room and available for your review at any time. A copy of this notice is also available to you upon request.

### **REMINDER CALLS**

A courtesy call will be made to confirm **WELL** appointments **ONLY**. If there is no answer a message will be left on the phone listed as the patient's home number. If we are unable to reach you, the responsibility of keeping the appointment is still yours.

### **NO SHOW FEES**

If proper notification is not given to our office, there will be an office visit charged to your account for a missed appointment. Physical exams and extended visits (EX: ADHD, Depression, Chronic Problems, etc.) have to be cancelled during office hours the day prior to the appointment. Fees for missed appointments: ear rechecks \$25, physical exams and regular scheduled visits \$50, extended visits \$75. After three missed appointments we reserve the right to immediately dismiss you from our practice.

### **PAYMENTS AND CHARGES**

If you receive a statement, it is due upon receipt. We accept Visa and Master Card. There will be a charge of \$30 for returned checks. A service charge of \$15 will be added to your account for the following: (1) if your copay is not paid on the day of service (2) if no payment is made at time of service for self pay accounts, and (3) **monthly** on all delinquent accounts.

### **MEDICAID INSURANCE**

The only Medicaid Plans we accept in our office (for established patients only) are State Medicaid and CareSource. No vaccines are to be given in our office if you have either of these plans. If they are given, you give up the right to have the vaccines submitted to Medicaid or CareSource and will pay for them in full. If you have other insurance as primary, the payment of the vaccines has to be confirmed with that insurance. Even if the primary insurance says they will pay for the vaccines, and for some reason does not, the vaccines will not be submitted to Medicaid or CareSource. The responsible party bringing the child in for the visit will be charged for the balance.

### **COLLECTION ACCOUNTS**

If your account is sent to collection, you will be responsible for the total amount on your account and a \$25 processing fee. You will also be responsible for any collection agency charges or attorney fees that are ensued.

Signature of responsible person: \_\_\_\_\_

Printed: \_\_\_\_\_

Date: \_\_\_\_\_