Advanced Neighborhood Pediatrics

12239 Cypress Spring Road
Clarksburg, MD 20871
Ph: (240) 374-8616 & fax: (240) 780-7159

Thank you for choosing our office. In order to serve you properly, we need the following information.
Please Print. All Information will be confidential.

Responsible Party Information

The following is for: □the person responsible for payment
Name:_____□ Male □ Female □ Married □ Single □ Child □ Other:_____
Social Security#:_____ Birth Date:_____
Phone (Home):_____ (Work):_____Ext:_____ Best time to call:_____
Address:_____
City:_____State:_____Zip Code:_____

Employment Information

The following is for: □the person responsible for payment

Employer Name:_____ Occupation:_____

Address:_____

City:_____State:_____Zip Code:_____

Insurance Information

Primary

Name of insured:_____ Is insured a patient? □Yes □No
Last First MI
Insured's Birth Date:_____ ID#:_____ Group #:_____

Insured's Address:_____
Street City State Zip Code

Insured's Employer Name:_____

Address:_____
Street City State Zip Code
Patient's relationship to insured: □ Self □ Spouse □ Child □ Other_____

Insurance Plan Name and Address:_____
_____

Secondary

Name of insured:_____Is insured a patient? □Yes □No
Last First MI
Insured's Birth Date:_____ ID#:_____ Group #:_____

Insured's Address:_____
Street City State Zip Code
Insured's Employer Name:_____

Address:_____
Street City State Zip Code
Patient's relationship to insured: □ Self □ Spouse □ Child □ Other_____

Insurance Plan Name and Address:_____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. All emergency services, or any clinical services performed without previous financial arrangements, must be paid for in cash at the time services are performed. Patients who carry health insurance with co-pay understand that all services furnished are charged directly to their health insurance except for their co-pays.. I grant my permission to you or your assignee to telephone me at home or at my work to discuss matters related to this form. I understand and agree that as a courtesy to the doctor, staff, and other patients, 24 hour prior notice must be given in the event of canceling, and or rescheduling an appointment I further understand that if I fail to give proper notice a broken appointment charge will incur, to which I am responsible. I have read the above conditions of treatment and payment and agree to their content.

_____ Date:_____ Relationship to Patient: _____
Signature of patient, parent or guardian
_____ Date:_____ Relationship to Patient: _____ *Signature of guarantor of payment/responsible party*

Please take the completed form to the front desk with your current insurance cards. Thank you for choosing ANP.