WELCOME!

Dr. Olsen and his staff would like to welcome you to our practice.

If you are a new parent, first and foremost, congratulations! Please be aware insurance companies require newborns to be added to your policy within 30 days of their birth. Your insurance will ***not*** cover claims after 30 days if your baby has not been added. Also be sure to verify that Millennium Pediatrics and your baby's pediatrician are "in network." In addition, you may want to check the maximum amount allowed for your child's well visits and vaccines.

Prior arrangements are to be made ***before*** the date of service for any special circumstances. Millennium Pediatrics will not be responsible for any charges ***not*** covered by your insurance company.

If you are a new family to our practice, Millennium Pediatrics thanks you for allowing us to take part in the care of your child!

For any questions regarding coverage or billing, please contact our front desk associates at (630) 548-1100

MILLENNIUM pediatrics

PATIENT INFORMATION

Patient Name: _____ Sex: M_____ F_____
Date of Birth: _____ Age: _____ Student Yes____ No____
Patient Address: _____ Phone: _____
City, State, Zip: _____

HEAD OF HOUSEHOLD

Parent's First and Last Name: _____
Parent's Address: _____
Parent's Home, Work/Cell Phone: _____

Parent's First and Last Name: _____
Parent's Address: _____
Parent's Home, Work/Cell Phone: _____

IN CASE OF EMERGENCY, NOTIFY:
Name: _____ Relationship: _____ Phone: _____

INSURANCE INFORMATION

Primary Insurance Company: _____
Insurance Company Address: _____
Subscriber Name: _____ Sex: M____ F____
Subscriber Date of Birth: _____ Relationship to Patient: _____
Plan ID: _____ Group # _____
Employer: _____
Secondary Insurance Company: _____
Insurance Company Address: _____
Subscriber Name: _____ Sex: M____ F ____
Subscriber Date of Birth: _____ Relationship to Patient: _____
Plan ID: _____ Group #: _____
Employer: _____

How were you referred to this office?
PPO/HMO _____ Relative/Friend _____ Neighborhood/School Publication _____ Physician _____
Hospital _____ Other _____

I hereby authorize my insurance benefits to be paid directly to the above signed physician, realizing I am responsible to pay non-covered services and I hereby authorize the release of pertinent medical information to insurance carriers.

Signature: _____ Date: _____
Relationship, if patient is a minor: _____

MILLENNIUM pediatrics

2712 Forgue Drive Suite 100, Naperville, IL 60564
Phone: 630-548-1100 Fax: 630-428-4211

PLEASE READ CAREFULLY AND CHOOSE 1 OF 2 OPTIONS BELOW:

OPTION #1

I, _____, give my permission to the clinical staff of Millennium Pediatrics, to leave a detailed message pertaining to any lab/x-ray results for my child, in the event that I am unable to be reached.

Child's Name: _____ Date Of Birth: _____

Home #: _____ Cell #: _____

Parent Signature: _____ Date: _____

E-Mail: _____

OPTION #2

I, _____, DO NOT give my permission to the clinical staff of Millennium Pediatrics, to leave a detailed message pertaining to any lab/x-ray results for my child, in the event that I am unable to be reached. I would prefer that a message is left and I call back to receive results.

Child's Name: _____ Date Of Birth: _____

Home #: _____ Cell #: _____

Parent Signature: _____ Date: _____

E-Mail: _____

Please provide a preferred Pharmacy:

Name: _____Location:_____

Phone Number (if known): _____

Financial Policies

Thank you for choosing our practice for your child's health care. As a team, we are committed to providing the best health care for your child. Understanding the following financial policies is important, so feel free to ask any questions of our patient service representatives.

Millennium Pediatrics charges what is customary for the services we provide. Your insurance company is billed, and based on the fee schedule we have agreed to with each company, we receive their payment. You may have copays, deductibles and other out of pocket expenses that are standard for most insurance. Please pay your copay at the time of service, and provide the front desk with accurate and timely insurance information. We ask for your current insurance information at each visit so that we can correctly file the claims. Incorrect insurance information will result in transfer of your balance to self-pay.

Please be aware that we are not contracted with all insurances, and you may be responsible to pay in full at the time of service.

Some insurance may not cover certain charges such as well child care, vaccines and other medically necessary tests. If your insurance company does not cover these items it will be your responsibility to pay for them. There are many insurance policies and we are unable to know the terms of each one. Please contact your insurance company if you are concerned that a charge has not been covered.

When electronically submitting claim information to insurances, it is necessary to release medical and other registration information to the billing agent/clearinghouse and to insurance companies of individuals having responsibility for authorization and/or payment of health services.

CANCELLATIONS/NO SHOW POLICY:
24 hour notice is required for cancellations so that we can best accommodate our other patients. Failure to cancel within 24 hours or no show will result in a $45 fee. Cancellation or no show for same day sick visits will be billed a fee of $45.

LATE ARRIVAL POLICY:
Late arrivals may be seen at the provider's discretion, if the schedule allows. It may be necessary to reschedule the appointment. Repeated late arrivals will be charged a fee of $45.

I have read the above policies for Millennium Pediatrics. I agree to the terms above and consent to the release of medical information to insurance providers as mentioned above. I also understand that my account is considered delinquent if no payment is received within 60 days of receiving a bill from Millennium Pediatrics. Delinquent accounts may be referred to a collections agency.

Signature: _____ **Date:** _____

Acknowledgement of Receiving Notice Of Privacy Practices and Welcome Letter

I acknowledge that I have received a Notice of Privacy Practices on the date below on behalf of Millennium Pediatrics. I understand that the Notice describes the uses and disclosures of my protected health information by Millennium Pediatrics and informs me of my rights with respect to my protected health information. I also acknowledge that I have received a copy of Millennium Pediatrics' welcome letter, which describes the practice's policies regarding new patients and insurance coverage.

Signature of Legal Representative: _____

Print Name of Legal Representative: _____

Date: _____

Relationship of Legal Representative: _____