Dr. Steven Alcuri

Pediatric & Adolescent Medicine
198 Thomas Johnson Drive   Suite 14
Frederick, MD 21702

Patient Information:

Name: Last ____

First ____ MI ____

Address ____

City ______________________   State______   Zip code ________________

Date of birth: ____________________   Age_______   Sex: Male   Female   Marital status   S M W D

Primary Phone # _________________________   Cell # ___________________

Guarantor / Responsible Party: (*Parent/Patient who is signing THIS FORM/giving permission to treat & Promise to Pay*)

(Please do NOT sign for another parent/guardian)

Name: Last ____

First ____ MI ____

Address ____

City _________________________   State________   Zip code _____________

Date of birth: _________________   Sex: Male   Female

Social Security # _____________________________   Relationship to Patient: __________________

Primary Telephone #: _______________________   Cell /Work #   __________________________

Employer ____

Employer's address ____

Signature of Guarantor: ____

Today's Date: ____

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Statement of Patient / Guarantor Financial Responsibility

This is a statement of our financial policy. You understand that you are obligated to ensure that our fees are paid in full. We bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

Insurance

If we are billing insurance, you agree that you will pay any deductible and co-payment or co-insurance as determined by your insurance plan. Those payments will be due at the time of service. Many insurance companies have additional requirements or stipulations that may affect your coverage. You are responsible for any amounts not covered or payable by your insurance. If your insurance denies any part of your claim, you agree to be responsible to pay the full balance.

Cancelling/Rescheduling an Appointment

Please be respectful to other patients and contact us promptly if you need to change or cancel your appointment. We require a 24 hour notice from time of the appointment (Monday through Friday) so that your appointment time can be reallocated to someone else. If you do not provide 24 hours notice it will be considered a “no-show” appointment.

No Show Policy

A “No Show” is someone who misses an appointment without canceling it at least 24 hours in advance or who fails to attend a scheduled appointment. In the event a 24 hour notice is not provided, you will be charged a fee of **$25.00** regardless of reason. This fee cannot be covered by insurance and will remain on your account until paid.

Past Due Accounts

Past due accounts may be filed in the Frederick County Courts for judgment. We are open to establishing a regular payment plan, so please contact the office if this is necessary. If your account becomes past due after a payment plan has been established, the account may also be sent to the Court for judgment. Additional collections fees may be added to your account.

Returned Checks/Insufficient Funds

A $35 fee will be charged for returned checks in addition to any remaining balance left unpaid.

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ACKNOWLEDGEMENT:

I have read and understand the financial policy described above. I agree to pay, promptly and in full, any amounts due to the provider, including co-payments, deductibles, and amounts due for non-covered or services that are not payable by my insurance.

MEDICAID / MCO PATIENTS ONLY

Since the state prohibits us to charge for NO SHOW appointments, we reserve the right to the following:
If you accumulate 3 No Show/Missed Appointments, regrettably we have no choice but to discharge your child/family from our practice. We will also contact the Local Health Department, within the county you reside along with your MCO. We are obligated to inform these entities of “Non-Compliance” concerning the healthcare needs of your child. Our practice strives to provide your child with the highest level of care, of which we can not provide when you do not come for your appointments.

I hereby authorize Dr. Steven Alcuri to apply for benefits on my behalf for covered services rendered. I request payment to be made directly to Dr. Steven Alcuri or to the party who accepts assignment. I certify that the information I have reported with regard to my insurance coverage is correct and further release of any necessary information, including medical information for this or any related claim, to the above named billing agent. This authorization may be revoked by either me or above named carrier at any time in writing.

Patient or Parent/Guardian Name: ____

Relationship to Patient: ____

Patient Name: ____

Date of Birth: ____

**** Copy of the Insurance Card / Front and Back will be attached to this form.**

Should your insurance change at any time, please be sure to let us know right away. If you fail to notify us of insurance changes, we are unable to bill to the appropriate carrier on your behalf.