



Amanda R. Lloyd, MD

Patient Information

Patient's name _____
Patient's date of birth _____
Primary physician _____
Patient address _____
Patient phone number _____
Preferred pharmacy _____

Parent name _____	Parent name _____
Date of birth _____	Date of birth _____
Social Security # _____	Social Security # _____
Address (if different than above): _____ _____	Address (if different than above): _____ _____
Home phone _____	Home phone _____
Cell phone _____	Cell phone _____
Work phone _____	Work phone _____
Employer _____	Employer _____
Email address _____	Email address _____

Patient Insurance (if card not available at appointment)

Insurance company _____
Name of subscriber _____ Date of birth _____
ID number _____

- Payment for all services not covered by your insurance (including co-payments and partial deductible payments) is expected at the time of your appointment unless other arrangements are made.
- You will also be responsible for any payment for any services requested and/or approved by you, but not covered by your insurance carrier.
- In addition, you will be responsible for any services rendered to your child(ren) for services requiring interpretation by an outside agency and billed by them directly (i.e. Labs, etc.). (It is the responsibility of the patient (parents/guardians) to know what is covered and not covered by their insurance carrier.)
- If Bright Steps Pediatrics does not participate with your insurance or if you are uninsured, full payment is expected on the date of service.
- It is the policy of Bright Steps Pediatrics that both a father and mother are responsible for a minor's care and bills, regardless of any other financial/legal arrangement dictating who will pay for the child's care.
- By signing below, I/we agree to the above terms and to keep my/our account current with timely payments. All accounts not current are subject to the Bright Steps Pediatrics collection program.

Parent/patient (if over 18 yrs.) signature _____ date _____