Just Kids RI Sick Care, LLC
Phone: 401-658-CARE FAX: 401-658-0800

Patient's Last Name: _____ First Name: _____ Date of Birth: __/__/___

Sex: Male or Female Social Security: ___-___-____ Address: _____

Apt # _____ City: _____ State: _____ Zip: _____

Home Phone: ( ) ____-_____ Cell Phone: ( )____-_____ Email: _____

Race: _____ Ethnicity: _____ Primary Care Physician: _____

Pharmacy:_____ PCP phone number: _____

PARENT/GUARANTOR INFORMATION

Last Name: _____ First Name: _____

Date of Birth: ___/___/___ Sex: Male or Female Address (if different from above): _____

City: _____ State: _____ Zip: _____ Home #: ( )____-_____

Cell Phone: ( ) - Social Security: - -

PRIMARY INSURANCE

Insurance: _____ Subscriber #: _____

Group Number: _____ Insurance Address: _____ State: _____

Zip: _____ Subscribers Name: _____ Date of Birth: _____

Relation: - Social Security: - -

SECONDARY INSURANCE

Insurance: _____ Subscriber #: _____

Group Number: _____ Insurance Address: _____ State: _____

Zip; _____ Subscribers Name: _____ Date of Birth: _____

Relation: Social Security: - -

It is your responsibility to know and understand how and if your health insurance will pay for this visit.
Our billing office does its best to request referrals on your behalf but if your insurance requires a referral from your primary care physician for this visit and we do not receive one, it is your responsibility to pay for the visit.

We interpret and accept the understood co-pay and or basic deductible as shown on your health insurance card; but due to factors pertaining to coding by the provider (first office visit and procedures performed) your total financial responsibility may be more after your insurance has processed the claim. the balance will be billed and due within 30 days.

Please direct any billing questions to your health insurance company or call our billing office Monday through Friday 9 am - 4 pm (401)- 658-2525. An active health card is required at each visit and if your insurance is not in effect at the time of visit, you are responsible for payment.

I HAVE READ AND AGREE TO ALL OF THE ABOVE

Patient/Guardian Signature: _____ Date: _____