PREFERRED PEDIATRICS P.A.
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CHILD'S NAME _____

INSURANCE INFORMATION:

Primary Insurance Company _____ Co-pay _____

Policyholder's Name _____ Birth Date _____

Social Security #_____ ID#_____ Group #_____

Employer Name and Phone Number _____ #_____

Insurance Company Address and Phone: _____
(Phone No.)

_____
(Street or box #)

_____
(City, State, Zip)

Secondary Insurance Company _____ Co-pay _____

Policyholder's Name _____ Birth Date _____

Social Security #_____ ID#_____ Group #_____

Employer Name and Phone Number _____ #_____

Insurance Company Address and Phone: _____
(Phone No.)

_____
(Street or box #)

_____
(City, State, Zip)

INFORMATION CONCERNING FILING A CLAIM WITH YOUR INSURANCE COMPANY

If we participate with your primary insurance, Preferred Pediatrics P.A. will gladly file a claim for you. We will allow your insurance company up to 45 days from the date of service to pay the claim. If your company fails to fully compensate Preferred Pediatrics P.A. any unpaid balance becomes the sole responsibility of the insured and is due upon notification from our office. Any co-payments or payment for non covered service are due at the time of service. Preferred Pediatrics P.A. **cannot bill for co-payments.** Guarantor will be responsible for collection agency fee if account is turned over for collection.

AUTHORIZATION TO FILE INSURANCE CLAIMS, TO RELEASE MEDICAL INFORMATION, AND ASSIGNMENT OF BENEFITS

I hereby AUTHORIZE Preferred Pediatrics P.A. to file insurance claims for services and supplies rendered to and for my child(ren). I also AUTHORIZE Preferred Pediatrics P.A. to release information, including my child(ren)'s medical and billing information, to my referring doctor, insurance company, or the responsible party named above. I hereby ASSIGN to Preferred Pediatrics P.A. all payments for medical services rendered to my dependant child(ren).

ACKNOWLEDGEMENT

I ACKNOWLEDGE that the above information is correct that I am responsible for the balance on my account for any services not covered by my plan.

Signed: X_____ Date:_____