

Insurance Coverage Information: Please show all numbers on your card(s)

Primary Insurance Coverage

Insured (Name on card): _____ Insured ID Number: _____
Insurance Company Name: _____ Group/Member/Policy Number: _____
Address: _____ Effective _____
Date: _____
City: _____ State: _____ Zip Code: _____
Telephone Number: _____

Secondary Insurance Coverage

Insured (Name on card): _____ Insured ID Number: _____
Insurance Company Name: _____ Group/Member/Policy Number: _____
Address: _____ Effective _____
Date: _____
City: _____ State: _____ Zip Code: _____
Telephone Number: _____

AUTHORIZATION TO PAY BENEFITS TO THE PHYSICIAN. . . .

I hereby authorize the office of Pensacola Pediatrics, to release any medical information required during the course of examination and treatment and permit payment directly to them any benefits due for their services rendered. I recognize and accept responsibility for services rendered regardless of insurance coverage. This includes but is not limited to coinsurance, copayment, deductible and non-covered services. I have received a copy of Pensacola Pediatrics' HIPAA Notice of Privacy Practices.

Date: _____

Signature of Parent and/or Guardian: _____

I AUTHORIZE THE FOLLOWING NAMED INDIVIDUAL(S) TO BRING MY CHILD IN FOR TREATMENT.

Name: _____ Phone #: _____ Relationship: _____

Name: _____ Phone #: _____ Relationship: _____

Chart Up Date		
Initials checking pt in		