INSURANCE INFORMATION

Patient Name_____ **DOB**_____
Last First Middle

Primary Insurance Company_____
Phone number of Insurance Company_____
Policy Holder Name_____ Relationship to Patient_____
Policy Number_____ Group Number_____
Employer of Policy Holder_____
Policy Holder SSN_____ Policy Holder DOB_____
Does this insurance company allow in house labs to be performed? _____
Which laboratory does insurance prefer for send out labs? _____

Secondary Insurance Company_____
Phone number of Insurance Company_____
Policy Holder Name_____ Relationship to Patient_____
Policy Number_____ Group Number_____
Employer of Policy Holder_____
Policy Holder SSN_____ Policy Holder DOB_____
Does this insurance company allow in house labs to be performed? _____
Which laboratory does insurance prefer for send out labs? _____
Does your insurance cover immunizations? _____

I understand that it is my responsibility to know which services my insurance plan covers, and if the information I provide is incorrect, I will be responsible for payment for charges.

Signature_____
Relationship to Patient _____
Date_____

Authorization to Release Information and Assignment of Benefits

I hereby authorize the release of medical information necessary to file a claim with my health insurance company, and I authorize the assignment of benefits, otherwise payable to me. to Kids First Pediatrics of Georgia. I understand that I am financially responsible for payment for services rendered which are not covered by my insurance company.

Signature_____
Relationship to Patient _____
Date_____

Authorization for Additional Charges

I understand and agree that there will be a returned check fee of $30.00. If my account is turned over to a collection agency, I will be responsible for all collection fees. If legal action is taken to collect my debt I will be responsible for all attorney fees and court costs. I understand that if an account has been sent to a collection agency, all balances must be paid in full before any future appointments can be scheduled..

Signature_____
Relationship to Patient _____
Date_____