RIVERSIDE PEDIATRICS

AUTOMATIC INSURANCE CLAIM SUBMISSION

Please complete and list all children in your family:

Patient Name: _____ DOB: ____/____/____

Patient Name: _____ DOB: ____/____/____

Patient Name: _____ DOB: ____/____/____

Patient Name: _____ DOB: ____/____/____

Patient Name: _____ DOB: ____/____/____

Patient Name: _____ DOB: ____/____/____

Parent/Guardian Name *(Please Print)* _____ DOB: ____/____/____

PAYMENT RESPONSIBILITY:

As a service, Riverside Pediatrics will submit claims to most insurance carriers, if provided with policy numbers, address and any other patient information needed.

I understand that I assume responsibility for any deductible, current co-payment or other balance not covered by my insurance carrier.

I have read the above and accept that I am financially responsible for all charges whether or not paid by my insurance.

Parent/Guardian Signature _____ Date: _____

AUTHORIZATION:

I authorize Riverside Pediatrics to release any medical information including diagnosis, x-rays, test results, reports, and records pertaining to any treatment or examination rendered. I understand that this medical information may be used for any of the following purposes: Diagnostic, insurance, legal, and when the provider deems necessary to ensure the best medical care for the patient. I further understand that any persons that receive these medical records will not release any of the medical information obtained by this authorization to any other person or organization without a further authorization signed by me for release of information.

I authorize the release of any medical information necessary to process claims. I authorize Riverside Pediatrics to submit claims to my insurance company on my behalf and my insurance company to pay them directly. I permit a copy of the authorization to be used in place of original. This authorization may be revoked by me at any time in writing.

Parent/Guardian Signature _____ Date: _____