(Your health plan and the lawyers make us have this next part.)

Insurance Information

Do you have coverage for the patients in your family? YES NO
Please provide your insurance card today and each time your child is seen in our office.

Insurance Company_____ Effective Date_____

Insurance subscriber name_____

Relationship to the patient(s) being seen_____

I hereby authorize Partners in Pediatrics, P.C. to release information about my child's doctor visits to my insurance company if requested. **I understand that if my insurance company does not remit payment within 60 days (2 months) that I will be expected to pay my bill.** I agree that in the event that my account must be turned over to a collection agency or an attorney that I will be responsible for any fees and interest incurred from the collection process. **Fees incurred are payable when services are rendered and are the sole responsibility of the parent and/or legal guardian.**

Mother's Signature _____ **and/or Fathers Signature**_____

Or Legal Guardian _____ **Relationship to patient**_____

HIPPA STATEMENT I have received a copy of the Partners in Pediatrics Notice of Privacy Practices, and have had an opportunity to read it. I understand that I may ask questions to Partners in Pediatrics if I do not understand any information contained.

_____ _____

Signature of Parent or Legal Guardian Date of Signature

Partners in Pediatrics

Updated or Reviewed?

_____ **Initials** _____**Date**