PEDIATRIC ASSOCIATES MEDICAL GROUP, INC.
PRACTICE LIMITED TO INFANTS, CHILDREN, AND ADOLESCENTS

# AUTHORIZATION TO TREAT AND SUBMIT CLAIMS

Assignment of Benefits
I authorize the assignment of benefits payable to **Pediatric Associates Medical Group, Inc.** and/or its designee for physician services and supplies by government and/or any other private third-party payer. I understand that I will be held responsible for payment of all co-payments, co-insurance, deductibles, and non-covered services.

Authorization for Release of Information
I authorize **Pediatric Associates Medical Group, Inc.** to release to my insurance carrier, or its designated agents, any information concerning medical care, advice, treatment, or supplies provided to me for purposes of administration, review, investigation, or evaluation of claim coverage and utilization of services. I authorize that a copy of this information be as valid as the original.

Authorization for Additional Fees
I will be responsible for any and all costs that may incur in the event of a lawsuit or action that is brought to collect this account or any portion thereof. I am aware that there will be a **$50.00 non-covered fee** for any no-show appointments or appointments that are not cancelled prior to 24 hours.

Authorization for Treatment
I agree to any examination, treatments, and procedures that may be performed during my child's office visits, including X-ray and emergency treatment considered necessary by the physician and/or his/her providers.

______________________________ ______________________________
Name of Patient/Legal Guardian Relationship to Patient

______________________________ ______________________________
Signature of Patient/Legal Guardian Date

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