Permission to Bill Insurance

Child: ______________________ D.O.B.: ____________________ Sex: M/F

Mailing Address: _______________________________

____

Please Circle one of the following:

Race: Asian Black Hawaiian White Unknown

Ethnicity: Hispanic/Latino Non-Hispanic/Latino

Primary Language: ______________________________

Parent Responsible for Bills/Account:

Parent Name: __________________________________

Parent Billing Address: Same as above or as listed below

____

____

Primary Health Insurance Policy:

Policy Holder's Name: ____________________________
D.O.B.: __________________________
Insurance Company Name: __________________
Policy ID: ________________________
Employer:_______________________________________

Secondary Health Insurance Policy:

Policy Holders Name: __________________________
D.O.B.: __________________________
Insurance Company Name: _________________________
Policy ID: __________________________
Employer: _______________________________________

I give permission to Ideal Pediatric and Adolescent Care to provide medical treatment of the above-named child. I understand that I am financially responsible for non-covered charges. I hereby assign my insurance benefits to be paid directly to the physician and to release any information necessary to process my claim

Signature: ______________________________Date: ______________