

Emmason Pediatric & Family Clinic
PEDIATRIC INSURANCE INFORMATION

Reason for your visit: _____ Date: _____

Name (Last): _____ (First): _____ (Middle): _____

Address: _____ APT: _____

City: _____ State: _____ Zip: _____

Home Phone#: _____ Cell: _____ Work: _____

SS#: _____ DOB: _____ Age: _____

Mother's Name: _____ Phone #: _____

Father's Name: _____ Phone #: _____

Emergency Contact: _____ Phone#: _____

Address: _____

SIBLINGS: _____

INSURANCE NAME: _____

INSURANCE ID #: _____ **GROUP #:** _____

INSURED'S NAME: _____ **EMPLOYER:** _____

INSURANCE PHONE #: _____

Acknowledgement & Authorization

I consent to treatment as necessary or desirable to the care of the patient named above, including but not restricted to whatever medicine, conduct of laboratory, x-ray, or other studies that may be used by the attending medical provider or her qualified designee. I acknowledge full responsibility for the payment of such services and agree to pay them in full at the time of service, unless other arrangements are made with the office staff. I understand that insurance coverage is an arrangement between the insurance carrier and the patient. Emmason Pediatric and Family Clinic will assist in billing my insurance company, but I am ultimately responsible for payment should my insurance fail to pay within a reasonable time. I authorize Emmason Pediatric and Family Clinic to release my information as required by my insurance or third party payor (including workers compensation) for the purpose of determining benefits. I understand that such records may include information regarding HIV/AIDS testing, substance abuse, and/or mental health issues. I also authorize Emmason Pediatric and Family Clinic to bill my insurance or third party payer, and receive payment directly from them for services rendered to me. A photo copy of this authorization shall be deemed as valid as the original.

Signature (Patient or Guardian): _____ Date: _____

(Legal Guardian does not include step-parent unless authorized by the court)