Insurance Information

Child's Name: First ________________________ Last ___________________ Date of Birth ______________

Primary Insurance

Policy Holder's Full Name: First _____________________________ Last ______________________________

Social Security Number _________________ Date of Birth ______________ Relationship to child __________

Address (if different than child's) ____

City ___________________________ State _____ Zip ________________

Phone ( ) _____________________ Work ( ) _________________

Employer ____ Address _____________________________

City ________________________ State ________ Zip ________________

Insurance Company ____ **ID#** ___________________________

Group#________________________ **Effective Date of Insurance** _____________________________________

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WE DO NOT ACCEPT SECONDARY INSURANCE, EXCEPT IN CASES OF DISABILITY

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Disability (Secondary) Insurance *(Such as Medicaid)*

Policy Holder's Full Name: First _____________________________ Last ______________________________

Social Security Number _________________ Date of Birth ______________ Relationship to child __________

Address (if different than child's) ____

City ___________________________ State _____ Zip ________________

Phone ( ) _____________________ Work ( ) _________________

Employer ____ Address _____________________________

City ________________________ State ________ Zip ________________

Insurance Company ____ **ID#** ___________________________

Group#________________________ **Effective Date of Insurance** _____________________________________

PAYMENT AND ASSIGNMENT OF BENEFITS

It is the office policy that all payments for insurance mandated copayments and/or balances for medical services be made at the time of your visit. This payment is required regardless of who brings the child in to be seen. In the case of separated or divorced parents, responsibility and payment shall belong to the guardian bringing the child in for treatment. For example, if parent/guardian #1 is financially responsible for medical expenses, and parent/guardian #2 is bringing that child in for treatment, payment will be expected from parent/guardian #2 at the time of service.

I hereby give my permission to Aspen Pediatrics to release any pertinent information to my insurance company upon request. I further authorize assignment of benefits for medical services rendered to Aspen Pediatrics.

____________________________ ________________________________ ______________

Signature Print Name Date