

HUDSON VALLEY PEDIATRICS FINANCIAL INFORMATION

PATIENT NAME _____ DATE OF BIRTH _____

RESPONSIBLE PARTY

First Name _____ MI _____ Last Name _____

Street _____ Apt # _____ City _____

State _____ Zip _____ Home #(_____) _____ Work #(_____) _____

Date of Birth _____ SS # _____

Relationship to patient: Father Mother Other: _____

PRIMARY INSURANCE

Insurance Company: _____

Policy Holder: _____ Date of Birth _____

Employer: _____ SS # _____

Policy Holder's ID #: _____ Child's ID #: _____

Relationship to patient: Father Mother Other: _____

SECONDARY INSURANCE

Insurance Company: _____

Policy Holder: _____ Date of Birth _____

Employer: _____ SS # _____

Policy Holder's ID #: _____ Child's ID #: _____

Relationship to patient: Father Mother Other: _____

FINANCIAL AGREEMENT/ RELEASE

I authorize Hudson Valley Pediatrics to release any information, including the diagnosis and the records of any treatment or examination rendered to my child during the period of such care, to third party payors and/or other health practitioners.

I authorize and request my insurance company to pay directly to Hudson Valley Pediatrics, insurance benefits otherwise payable to me. If my insurance does not cover a service, I will be responsible for the charge.

If I do not have insurance or the physician does not participate in my insurance, I agree to pay all charges at the time of service unless other arrangements have been made.

Signature of Parent/ Guardian

Date