Emerald Pediatrics

(Patients Ages 18-21)

*Date*_____ Primary Pediatrician_____

PATIENT NAME

Name_____ DOB_____ SS#_____

Address_____

City_____ State_____ Zip Code_____

Cell ( )_____ Other ( )_____

Email _____

Employer_____ Occupation_____

Are you still covered by parent's health insurance? Yes No

INSURANCE INFORMATION

Primary Insurance Co_____

Subscriber Name_____ Subscriber DOB_____

Address_____

City_____ State_____ Zip Code_____

Telephone ( )_____ Employer_____ Occupation _____

EMERGENCY CONTACT Relationship_____

Name_____ Telephone ( )_____

RELEASE OF INFORMATION AND PAYMENT AUTHORIZATION

All Other Insurance Companies and/or Third Party Payers: I HEREBY AUTHORIZE Emerald Pediatrics and/or any of its representatives to submit a claim to my Insurance Carrier or its intermediaries for all services rendered by the physician(s) and authorize and direct my insurance carrier or its intermediaries to issue payment directly to Emerald Pediatrics and or physician(s) rendering service. I authorize the release of any and all medical information to my insurance carrier or its intermediaries regarding services rendered.

Medicare and Medicaid: I certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me release to the Social Security Administration, Medicare, Medicaid, or it's intermediaries or carriers any and all information needed for this or a related Medicare or Medicaid claim. I authorize and request that payment be made directly to Emerald Pediatrics.

Guarantee of Payment: I UNDERSTAND that filing claim with my insurance company or other third party payor, under any circumstances, does not relieve me from my responsibility for the payment of all charges. I further acknowledge that I am responsible for the payment of all charges for services rendered by Emerald Pediatrics to me or the patient indicated. By signing this document I personally guarantee the payment of these charges for medical services rendered. This includes, but is not limited to claims filed for Worker's Compensation and/or claims due to personal injury accidents/illnesses.

I AGREE that this authorization shall be valid until rescinded or replaced on a later date.

PATIENT SIGNATURE_____ DATE_____