SF Bay Pediatrics

Medical Information and Claims Submission Authorization Form

THIS PAGE WILL ONLY BE ACCEPTED WHEN EACH SECTION BELOW HAS BEEN SIGNED.
Although not mandatory we request both parents' signatures, in the event the subscriber and/or the insurance carrier should change between the parents or dual coverage should exist. This authorization to file claims will remain on file for the duration of the patient(s) association with the practice.

Patient Name: ____ Date of Birth: ______/______/______

Patient Name: ____ Date of Birth: ______/______/______

Patient Name: ____ Date of Birth: ______/______/______

Patient Name: ____ Date of Birth: ______/______/______

* *

Parent 1 Name: (***Please Print legibly***) ______________________________ Date of Birth: ______/______/______

Parent 2 Name: (***Please Print legibly***) ______________________________ Date of Birth: ______/______/______

PAYMENT RESPONSIBILITY: As a service, SF Bay Pediatrics will submit claims to most insurance carriers, if provided with policy numbers, address and any other patient information needed.
I understand that I assume responsibility for any deductible, current co-payment or other balance not covered by my insurance carrier.
I have read the above and accept that I am financially responsible for all charges whether or not paid by my insurance.

Signature ____ Date: ______________
(Patient, Parent **1**, or Guardian)

Signature ____ Date ______________
(Parent **2**, or Guardian)

AUTHORIZATION: Medical Information Release for Medical Management and Claims Submission

I authorize SF Bay Pediatrics to release medical information including diagnosis, x-rays, test results, reports, and records pertaining to any treatment or examination rendered for coordination of care to provide your child with the most comprehensive advice, medical care and treatment. I further understand that any persons that receive these medical records will not release any of the medical information obtained by this authorization to any other person or organization without a further authorization signed by me for release of the information.

I authorize the release of any medical information necessary to process insurance claims. I authorize SF Bay Pediatrics to submit claims to my insurance company on my behalf and my insurance company to pay them directly. I permit a copy of the authorization to be used in place of original. This authorization may be revoked by me at any time in writing.

Signature ____ Date: ______________
(Patient, Parent **1**, or Guardian)

Signature ____ Date ______________
(Parent **2**, or Guardian)