



Patient/Child's Name _____ Date of Birth: _____

INSURANCE INFORMATION

PRIMARY INSURANCE:

Policy Holder Name: _____ Relationship to Patient: _____
 Date of Birth: _____ Social Security Number: _____
 Patient's ID#: _____ Patient's Group#: _____
 Effective Date: _____ Today's Date: _____

SECONDARY INSURANCE:

Policy Holder Name: _____ Relationship to Patient: _____
 Date of Birth: _____ Social Security Number: _____
 Patient's ID#: _____ Patient's Group#: _____
 Effective Date: _____ Today's Date: _____

Please list all children who currently are, or will be, patients at Hackensack Pediatrics

Name: (last, first MI)	Sex (M/F)	Date of Birth:	Same Insurance?
_____	_____	_____	Y / N
_____	_____	_____	Y / N
_____	_____	_____	Y / N
_____	_____	_____	Y / N
_____	_____	_____	Y / N

RESPONSIBLE PARTY (GUARANTOR)

Responsible party (Guarantor) is the individual who agrees to accept financial responsibility for the payment of all services performed at Hackensack Pediatrics. This individual may not necessarily be the insurance cardholder. Responsible Party must read and sign below.

Name _____ Relationship to Patient _____

Address _____

E-mail Address: _____ Occupation: _____

Social Security Number: _____ Phone (Home): _____

(Cell): _____ (Other Phone #): _____

I certify that the information I have reported with regards to my insurance coverage is correct. I authorize the release of any medical information necessary to process this claim and I permit a copy of this authorization to be used in place of the original. I also acknowledge that all charges are subject to a service charge of 1.5% per month after 60 days from date of service. Furthermore, I agree to pay any collection costs and legal fees incurred by this office with respect to these charges.

SIGNATURE: _____ **DATE:** _____

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of surgical/medical benefits to the PHYSICIANS at HACKENSACK PEDIATRICS for services rendered by them in person or under their supervision. I understand that I am financially responsible for any balance not covered by my insurance.

NAME: _____

SIGNATURE: _____ **DATE:** _____

CHILD ADVOCACY

As advocates for our young patients, Hackensack Pediatrics will not intervene in any custody disputes, or financial responsibility disputes, between parents or other responsible parties. The office will send statements to the address provided. However, we will not look to more than one party to fulfill financial responsibility.

NAME: _____

SIGNATURE: _____ **DATE:** _____