PRIMECARE PEDIATRICS
3229 Hwy 34 East, Suite 103
Newnan, GA 30265
Ph. (770) 251-5253; Fax (770) 251-5254
www.primecarepeds.com

PATIENT AND INSURANCE INFORMATION

Medical Record#: ___________

(Thank you for completing all Sections)
Children's names who will be patients as they appear on card or how they are listed with insurance company.

Last Name	First Name	Middle Name	Date of Birth	Sex
				M F
				M F
				M F
				M F
				M F

Mother's Name: __________________________ Father's Name: ____________________________

POLICY HOLDER'S INFORMATION OR PARENT/LEGAL GUARDIAN RESPONSIBLE FOR THE BILL

Full Names: ____

(Last) *(First)* *(Middle)*

Address: ____

Home Phone #: ( ) _____ ______ Work Phone #: ( ) ______ ________ Email: _________________

Social Security Number: ______ _____ ____________ Date of Birth: _______________________

Employer's Name and Address: ____

Employer's Phone Number: ( ) ____ _______ Emergency Contact Phone #: ( ) _____ ______

Name of Insurance: ____

Company Policy Number: __________________________ Group Number: _________________________

Co-payment amount if applicable: $ _______ Yearly deductible if applicable: $ _________

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION/ASSIGNMENT OF INSURANCE BENEFITS

A. Authorization is hereby granted to PrimeCare Pediatrics to release to my insurance company or companies, their agents, or other third party payors, confidential information (including copies of records) as may be requested or necessary for the completion of claim processing relative to treatment by the doctors of PrimeCare Pediatrics. I hereby release PrimeCare Pediatrics from all legal responsibility or liability that may arise from the release of such records.

B. The undersigned hereby authorizes payment directly to PrimeCare Pediatrics of the insurance benefits otherwise payable to him/her or due to become payable to him/her, but not to exceed the balance due of the charges for the treatment rendered. I understand and agree that I am financially responsible for any charges not covered by this assignment of insurance benefits. Also, for value received, I hereby assign to PrimeCare Pediatrics my rights under Georgia Law to have any insurance claim processed and/or paid within 15 working days of the insurance company's receipt of the proof of claim. This assignment is for consideration and is irrevocable. It is further agreed that any credit balance resulting from insurance payments or other sources that are refundable to the responsible party will be applied to my account balance not due by insurance that is due to PrimeCare Pediatrics by the insured or his/her family

Please sign by both X's and date

Guarantor/Responsible Guardian X_________________________ Relationship to Patient: __________

Insurance Policy Holder X________________________________ Relationship to Patient: __________

Today's Date: _______________________

FOR OFFICE USE ONLY
Name of insurance representative who verified coverage _____________________________________
Verified By: __________________ Date Verified: _________________