

WELCOME!

****Please fill out this entire form. We cannot file your insurance claim without this information****

Children's Names:

_____	DOB _____	M_____ F_____
_____	DOB _____	M_____ F_____
_____	DOB _____	M_____ F_____
_____	DOB _____	M_____ F_____

Address: _____
 City: _____ State: _____ Zip: _____ Phone: (____) _____
 Cell Phone-Dad _____ Cell Phone-Mom _____ Email _____
 Nearest Relative: _____ Phone: (____) _____ Relationship: _____

FATHERS NAME:	MOTHERS NAME:
Employer:	Employer:
Occupation:	Occupation:
Work Phone:	Work Phone:
Drivers License #:	Drivers License #:
Social Security #:	Social Security #:
Birthdate:	Birthdate:

REFERRED BY: _____

THIS AREA MUST BE COMPLETED FOR OUR OFFICE TO FILE YOUR INSURANCE CLAIMS

Self Pay (Please initial and date): _____

Primary Insurance: _____ Policy Holder Name & SS#: _____

ID or Policy #: _____ Policy Holder Date of Birth _____

GROUP#: _____ Effective date: _____

Secondary Insurance: _____ Insured Parent: _____

ID or Policy #: _____ Group#: _____

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- Appointments:** There will be a \$25.00 fee charged to your account for any missed appointments.
- Fee Policy:** Payment is expected at the time of service.
- Medical Care:** I authorize the physicians of Austin Children's Clinic, PA to provide my child with reasonable and proper medical care according to today's standards.
- Medical Information:** I authorize the physicians of Austin Children's Clinic, PA to release any information concerning my child's illness and treatments to consulting physicians, or to my insurance company or companies or any third party payor so that they may obtain payment for medical services rendered.
- Assignment of Benefits:** I authorize the insurance company or any third party to pay any benefits directly to the above physicians, realizing I am responsible to pay non-covered services. I understand that if the information I am providing today results in the insurance claims being denied, for any reason, I will be responsible for the full amount billed without the benefits or discounts.

SIGNATURE: _____ **DATE:** _____