STERLING PEDIATRICS
PAYMENT / INSURANCE INFORMATION

The following information must be completed. Sterling Pediatrics will file with your Primary insurance. After payment from your Primary carrier is received, we will submit to your Secondary insurance for payment.

Please present your insurance card and driver's license to be copied for our records.

Patient Name:_____Date of Birth:_____

Primary Insurance Company:_____

Group number:_____Policy Number:_____

Insurance address:_____

Secondary Insurance: _____

Policyholder Name:_____

SSN of Subscriber:_____Date of Birth:_____

Employer name:_____

Self-Pay-services provided are payable in full at the time of visit, unless other arrangements have been made.
_ I do not have insurance information to bill.
_ I have insurance that Sterling Pediatrics, PLLC does not participate with at this time.
_ I pay for my health care out of pocket.

I, the undersigned, certify that the information I have provided is correct to the best of my knowledge. I understand that incomplete or incorrect information may result in my being responsible for the entire bill. Co pays are due at the time of the visit unless other arrangements are made.
I also understand that I am responsible for services which are not payable by the insurance companies due to Employer Plan provisions.

I, further authorize the release of any information needed for processing my insurance claims. A copy of this authorization may be used in place of the original.

_____ _____ _____
Date Signature of Insured/ Parent or Legal Guardian Print Name