PEDIATRIC ASSOCIATES OF WESTMORELAND

GREENSBURG · NORTH HUNTINGDON · MOUNT PLEASANT · CONNELLSVILLE

AUTHORIZATION TO BILL INSURANCE

#1 Primary Insurance Name: _____ ID #: _____

Policy Holder Name: _____ DOB: _____

#2 Secondary Insurance Name: _____ ID #: _____

Policy Holder Name: _____ DOB: _____

I understand that all co-pays are due at the time of service and that I am financially responsible for all charges whether or not they are paid by my insurance. I hereby authorize Pediatric Associates of Westmoreland to release all medical information necessary to secure payment of benefits from the third-party payers specified above, and I authorize the use of this signature on all related submissions. I further understand that excessively overdue accounts may be forwarded to an outside collection agency and I will be responsible for any fees generated as a result of collection efforts. I understand that this authorization shall remain valid for (1) year of date signed.

Patient or Parent/Guardian Signature: _____ Date: _____

PATIENT COMMUNICATION PREFERENCES

Our offices use our Electronic Medical Records (EMR) system to notify patients of their upcoming appointments and remind them of routine well visits, etc. Please tell us if you prefer to be notified by *phone call* or by *text*. Our EMR system will attempt to reach Contact #1 first, and then attempt Contact #2 if Contact #1 cannot be reached.

Contact #1 Name: _____ Phone #: _____ ☐ Call ☐ Text

Contact #2 Name: _____ Phone #: _____ ☐ Call ☐ Text