Dr. T's Pediatrics PLLC

Tel # 718-520-8585

Fax# 718-520-8688

AUTHORIZATION OF INSURANCE BENEFITS AND RELEASE OF INFORMATION

I hereby authorize the providers of Dr. T"s Pediatrics PLLC to apply for benefits on my child's behalf for covered services rendered by them or by their order. I request that payments from my insurance company be made directly to the providers of Dr. T's Pediatrics PLLC (or to the party who accepts assignment).

I authorize the release of any medical information necessary to process this claim.

I certify that the information I have reported with regard to my child's insurance coverage is correct.

I understand that I am responsible for any balance not covered by my insurance.

I permit a copy of this authorization to be used in place of the original.

Date _____ Signature_____

Name: _____

Relationship: _____

I understand that I, at the time of service, I do not disclose **ALL AND CORRECT** insurance information including, but not limited to, private insurance, secondary insurance, Medicaid, ChildHealthPlus, etc., to Dr. T's Pediatrics PLLC or its representatives, I will be held financially responsible for all charges.

Date _____ Signature_____

Name_____

Relationship (parent or guardian)_____