GPM Pediatrics, PC

Patient Name_____Date of Birth_____

Primary Insurance Information

Primary Insurance Carrier Name	Primary Insurance Carrier Address and Phone
Policy Holder's Name (Responsible Party)	Employer/Group Name
Policy I.D. #	Group Number
Primary Care Physician chosen (if applicable)	

I, the undersigned certify that I (or my dependent) have insurance coverage with the above and assign directly to GPM Pediatrics, PC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I will be responsible for collection agency fees of 25% of the balance added to the amount owed if in the event my account is forwarded to our collection agency. I hereby authorize GPM Pediatrics, PC to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature Relationship to Patient Date

Insurance Coverage Waiver

I understand that my eligibility for coverage by my insurance company cannot be confirmed at this time. I wish to receive services from GPM Pediatrics, PC. If it is determined that I am not eligible for coverage, I understand that I will be responsible for payment of all services provided.

Signature of Parent/Legal Guardian:_____Date:_____

Medicaid Coverage Waiver

I understand that your office does not take straight Medicaid. I wish to receive medical services from GPM Pediatrics, PC. If it is determined that my Medicaid funded plan is not in effect at the time of the service then I am willing to take financial responsibility for the services rendered. If it is determined that I am not eligible for coverage, I understand that I will be responsible for payment of all services provided.

Signature of Parent/Legal Guardian:_____Date:_____