



Today's Date: \_\_\_\_\_

Insurance Information				
Name & Address of Primary Insurance Company			Name of Subscriber on Insurance Card	
Policy ID Number	Group ID Number		Subscriber's Home Address	
Policy Effective Date	Subscriber's Birthdate	City	State	Zip
Subscriber's Employer		Subscriber's Relation to Patient	Subscriber's Phone Number	

Name & Address of Secondary Insurance Company			Name of Subscriber on Insurance Card	
Policy ID Number	Group ID Number		Subscriber's Home Address	
Policy Effective Date	Subscriber's Birthdate	City	State	Zip
Subscriber's Employer		Subscriber's Relation to Patient	Subscriber's Phone Number	

Apply Updated Insurance Information to the Following Siblings:		
Patient's Legal Name <i>(First, Middle, Last)</i>	Date of Birth	This Patient's Individual Policy # or Suffix
Patient's Legal Name <i>(First, Middle, Last)</i>	Date of Birth	This Patient's Individual Policy # or Suffix
Patient's Legal Name <i>(First, Middle, Last)</i>	Date of Birth	This Patient's Individual Policy # or Suffix
Patient's Legal Name <i>(First, Middle, Last)</i>	Date of Birth	This Patient's Individual Policy # or Suffix
Patient's Legal Name <i>(First, Middle, Last)</i>	Date of Birth	This Patient's Individual Policy # or Suffix

Responsibility for Payment of Services Rendered	
<p>By signing below, I hereby authorize Bloomington Pediatrics to submit claims for services rendered to the insurance company/companies listed by me. I authorize the release of protected health information to said insurance companies for the processing of claims. I understand that I am responsible for payment of services rendered and agree to pay any fees for services not covered by insurance, including, but not limited to co-insurance and deductible amounts. I agree to pay at the time of service any co-payment required by my insurance. I also understand I will be held responsible for the payment of any collection fees should my account be sent into collection proceedings.</p>	
Signature of Guarantor / Responsible Party	Date