Hilltop Pediatrics

300 Highland Ave.Ste.542 | Sherman, TX 75092
Phone: 903.957.0050 | Fax: 903.957.0057

Authorization of Release of Medical/Insurance Information and Assignment of Benefits

______________________________ ______/______/________
Patient's name Date of Birth

______________________________ ______/______/________
If under age 18, Parent/Guardian's name Date of Birth

Insurance Information

______________________________ ______/______/________
Subscriber's name Date of Birth

______________________________ ______/______/________
Primary Insurance Company Effective Date

______________________________ ________________
Certificate of ID number Group Number

______________________________ ______/______/________
Subscriber's name Date of Birth

______________________________ ______/______/________
Secondary Insurance Company Effective Date

______________________________ ________________
Certificate of ID number Group Number

I hereby assign, transfer, and set over to **Hilltop Pediatrics** all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. I authorize the insurance to provide benefits, claim status, and limitations to determine coverage and payment of services. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance. Also, I permit a copy of this authorization to be used in place of the original. I also assign insurance benefits paid on my behalf by any and all insurance companies that cover the expenses I or spouse or child(ren) incur as the result of any diagnostic services or treatment provided by any Hilltop Pediatrics Staff member.

______________________________ ______/______/________
Subscriber/Parent/Patient/Guardian's signature (Primary) Date of Assignment

______________________________ ______/______/________
Subscriber/Parent/Patient/Guardian's signature (Secondary) Date of Assignment