FINANCIAL AUTHORIZATION

PATIENT NAME: _____

I UNDERSTAND THAT THE SERVICES BEING PROVIDED TO MY CHILD ARE NOT FREE AND ACCEPT THE RESPONSIBILITY FOR PAYMENT OF ALL OR ANY PORTION OF CHARGES NOT COVERED BY THE AUTHORIZATION SET FORTH BELOW:

1. _____ I AUTHORIZE MEDICAID TO BE BILLED. ID# _____

2. _____ I AUTHORIZE MY INSURANCE COMPANY TO BE BILLED:

INSURANCE COMPANY: _____

ADDRESS: _____

PHONE: _____ POLICY NUMBER: _____

GROUP NUMBER: _____ CERTIFICATE NUMBER: _____

I AUTHORIZE THE RELEASE OF ALL RECORDS REQUIRED TO ACT ON THIS REQUEST. I REQUEST THAT PAYMENT OF AUTHORIZED BENEFITS BE MADE ON MY CHILD'S BEHALF.

_____ _____

PARENT / GUARDIAN SIGNATURE **DATE**

_____ _____

WITNESS SIGNATURE **DATE**