LUDLOW PEDIATRICS, INC.

Patient's Name	**D.O.B.**
Patient resides with □ **Parent/Guardian #1** □ **Parent/Guardian #2** □ **Both** □ **Other**	

Parent/Guardian #1 Name **Relationship:**	Address (Street, City, State & Zip code**)**	Phone Number
Parent/Guardian #1 Employer	Occupation	Business Phone
Insurance Company Name	Policy/ID #	Group#
Insurance Company Phone #	**Parent/Guardian #1 D.O.B.**	**Parent/Guardian #1 SS#**
Parent/Guardian #2 Name **Relationship:**	Address (Street, City, State & Zip code)	Phone Number
Parent/Guardian #2 Employer	Occupation	Business Phone
Insurance Company Name	Policy/ID #	Group #
Insurance Company Phone #	**Parent/Guardian #2 D.O.B.**	**Parent/Guardian #2 SS#**

Authorization: I hereby authorize my Physician to furnish information to my insurance carriers concerning every visit, and hereby irrevocably assign to the Physician all payments for medical services rendered. I understand that as the parent/guardian seeking care for this patient, I am financially responsible for all charges whether or not covered by my insurance company. I understand that if the insurance information is incorrect, I am financially responsible for all charges. In order to control the cost of billing, Ludlow Pediatrics, Inc. requires office visits/co-payments to be paid at the time service is rendered.

Except in limited circumstances, such as in the case of an emancipated minor, both parent's/guardian's are financially responsible for their child(ren)'s care. When we provide services, we bill the appropriate insurance carrier. However, both parent's/guardian's remain responsible for any unpaid amount.

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Responsible Party Signature Today's Date