

Pediatric Professional Association

10600 Quivira Rd., Ste 210

Overland Park, KS 66215

Date _____ Chart Number: _____

Child's Name: _____ DOB: _____ Sex: _____

Child's Address: _____

Home Telephone: _____

Father's Name: _____ Work Telephone: _____

Mother's Name: _____ Work Telephone: _____

Name of Insured Person: _____ DOB _____

Employer's Name: _____ Insurance Company: _____

ID # _____ Group# _____

Release of Information for Insurance

I authorize the physicians and staff of Pediatric Professional Association to provide necessary and appropriate treatment for my child _____ .

I fully understand that I am responsible for charges incurred. I authorize the release of information required to process insurance claims benefits. A photocopy of this form is as valid as the original. If your insurance company has not paid, or this is not timely filed, you will be responsible for payment and any further filing. If your insurance changes and you do not notify us within 30 days, you will be responsible for payment.

Cancellation Fee Acknowledgment Notice: A \$25 fee will be charged to your account if you cancel without 24-hour advance notice for well checks; unless we agree that you were unable to attend due to circumstances beyond your control. Note: Insurance companies do not reimburse for cancelled appointments.

IMPORTANT

Release of information for other entities

If you desire Pediatric Professional Association to disclose your child's medical information to a third party, including but not limited to, your child's school or daycare, you must complete an authorization form.

This authorization is located on the other side of this paper. Pediatric Professional Association cannot disclose your child's medical information to a third party unless you complete and sign an authorization.

Signature of Parent/Responsible Party _____