

Westchester Park Pediatrics
222 Westchester Ave, Suite 202
White Plains, New York 10604

Insurance/Billing Information

Primary Insurance: _____
Name of Policy Holder: _____ Date of Birth _____
Policy Holder SS#: _____
ID # _____ Group # _____
Address to Mail Claim: _____

By my signature below, I hereby specifically authorize the physician and/or his agents to provide medical treatment to my child/ children. I also authorize Westchester Park Pediatrics PLLC to release any medical and personal information acquired in the course of treatment that is necessary to process insurance claims, and authorize my insurance company to make the payments for my child/children's medical services directly to the physician, realizing that I am responsible for any amount not covered/paid by my insurance. I acknowledge that I understand by the policies of the practice of W.P.P., as well as the HIPAA Privacy regulations, as set forth in the Practice Handbook, and will be bound by the provisions contained in the Handbook. I also authorize the practice to release any medical information or insurance information that requested by any, diagnostic imaging or clinical facility that the practice refers me to as part of my child/children's treatment. **If your account is delinquent and we have made several attempts to collect outstanding balances, your account will be turn over to a 3rd party collection agency. You will agree to pay all reasonable collection costs including attorney fees and court costs.**

Patient (Guardian) Signature: _____ Date _____