Kindercare Pediatrics

Patient Insurance Information and Agreement:

Primary Insurance Company:

Primary Insurance Company Name: ____

Check one: ☐ PPO ☐ EPO ☐ POS ☐ Self Pay

Name of Insured: ____________________________ Birthdate: ______________________

Social Security Number: ____

Policy Number (aka ID Number, Subscriber Number) _____________________________

Group Number:_______________________________ Effective Date: ________________

Secondary Insurance Company:

Secondary Insurance Company Name: ____

Check one: ☐ PPO ☐ EPO ☐ POS ☐ Self Pay

Name of Insured: ____________________________ Birthdate: ______________________

Social Security Number: ____

Policy Number (aka ID Number, Subscriber Number) _____________________________

Group Number:_______________________________ Effective Date: ________________

Eligibility Waiver and Assignment of Benefits and Financial Agreement:

I, __________________________________, affirm that I am eligible for insurance benefits with the above
Name of Insured
insurance companies, effective this date: ________________________.

I hereby give authorization for payment of insurance benefits made directly to Kindercare Pediatrics/Holly Wang, MD, Inc. for services rendered by the associated physician(s). I understand that I am financially responsible for all charges not covered, deemed not medically necessary, or not authorized by the insurance company. In the event of default, I agree to pay all costs of collection and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

__________________________________ ____________________________
Signature of Insured Date

__________________________________ ____________________________
Signature of Patient's Representative Name of Patient's Representative