Please check one:

☐ New Patient Registration

☐ Update Info

- ✓ If all children in the family are on the SAME insurance policy – one form needed per family
- ✓ If children are on DIFFERENT plans – please complete a separate form for each child

Child's Name	Date of Birth	Child's Insurance ID #	Suffix/Group #	PCP

Child's Address: _____

_____

Subscriber / Guarantor Info: (*The parent that holds the insurance policy and will receive the bills*)

Name: _____

Address: _____

_____

Phone: _____

Email: _____

Insurance Info:

Company / Plan Name: _____

Billing Address: _____

_____

Effective Date: _____

My Copay for primary care visits: $_____

*** Please be sure to contact your insurance company and list us as your child's PCP – if we are not listed, they may not pay for visits!*

Other Parent / Guardian names, address and phone # (if different from above):

_____ _____ _____

_____ _____ _____

Consent for Billing:

- I have read the Notice of Privacy Rights detailing my rights. I understand that medical information obtained by Andover Pediatrics may be used for treatment, payment, quality assessments and case management.
- I understand that I am responsible for providing Andover Pediatrics and my insurance company with correct information to allow Andover Pediatrics to bill for services rendered for my child. I authorize payment of benefits due to be paid directly to Andover pediatrics. I also understand that there may be times when services will be provided which may or may not be a covered service and I accept full financial responsibility for these services.
- I understand that I am responsible for paying my copays and deductibles in following with my insurance plan agreement.

_____ _____ _____

Printed Name Signature Date