

# STERLING PEDIATRICS

## PAYMENT / INSURANCE INFORMATION

The following information must be completed. Sterling Pediatrics, P.L.L.C. will file with your Primary insurance. After payment from your Primary carrier is received, we will submit to your Secondary insurance for payment.

**Please present your insurance card and driver's license to be copied for our records.**

Patient Name

Date of Birth

Primary Insurance Company:

Group number

Policy Number

Insurance address

Secondary Insurance:

Policyholder Name:

SSN of Subscriber

Date of Birth

Employer name

Self Pay-services provided are payable in full at the time of visit, unless other arrangements have been made.

I do not have insurance information to bill.

I have insurance that Sterling Pediatrics, PLLC does not participate with at this time.

I pay for my health care out of pocket.

I, the undersigned, certify that the information I have provided is correct to the best of my knowledge. I understand that incomplete or incorrect information may result in my being responsible for the entire bill. Co pays are due at the time of the visit unless other arrangements are made. *I also understand that I am responsible for services which are not payable by the insurance companies due to Employer Plan provisions.*

I, further authorize the release of any information needed for processing my insurance claims. A copy of this authorization may be used in place of the original.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Insured/ Parent or Legal Guardian

\_\_\_\_\_  
Print Name