



Pediatric Center of Round Rock, P.A. dba River Ridge Pediatrics

1526 Leander Road

Georgetown, Texas 78628

Phone 512-863-7586 Fax 512-863-5222

### INSURANCE AUTHORIZATION

Patient Name: \_\_\_\_\_ Patient Date of Birth: \_\_\_\_\_

### INSURANCE INFORMATION

- As a courtesy to our patients we have enrolled in many managed care programs. However, we do not take responsibility for items that are not covered by your individual plan.
- We will not file any claims for patients without an insurance card. You can request your insurance company to fax or provide you with insurance documentation of coverage that includes all billing information.
- We will not be responsible for any denied claims due to filing deadlines if new insurance is not presented to us at the time of service.
- Prior to the appointment, please be sure that you have contacted your insurance company to add your new baby/child to the insurance policy. If the claim is denied, you will be responsible for payment.
- It is advised that all patients verify (if not already known) to see if we are in network provider for your insurance.
- Check which lab your insurance company is contracted with.
- Our clinic holds an additional stock of state mandated immunizations available for you child free of charge if you meet the criteria of being underinsured. A \$5.00 charge per vaccine administration will apply.

### AUTHORIZATION

As a courtesy, River Ridge Pediatrics, will verify and file insurance, but the practice cannot guarantee payment. I understand that I am financially responsible for services rendered as and when charges are incurred. I hereby authorize River Ridge Pediatrics and/or the rendering providers to release all medical information required by my insurance company to file claims for medical benefits. I authorize payment of all applicable benefits directly to River Ridge Pediatrics. This authorization will remain in effect until revoked by me in writing. A photocopy is to be considered as valid as the original. Consent to release information acquired in the course of examination and/or treatment in regard to treatment, payment of services and operations is understood and explained to me in the posted Notice of Privacy Practices.

\_\_\_\_\_  
Parent/Guardian (Please Print) / Relationship

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date