**WESTON PEDIATRIC PHYSICIANS, P.C.**
**486 BOSTON POST ROAD**
**WESTON, MA 02493**

## Assignment of Benefits

Patient Name: _____ Date of Birth: _____

Address: _____ Home Phone : _____

_____ PCP: _____

Language: _____ Race: _____ Ethnicity: _____

Parent/Patient decline ☐ Parent/Patient decline ☐ Parent/Patient decline ☐

Siblings: PCP (primary physician's initial)

First Name: _____ _____ Date of Birth: _____

First Name: _____ _____ Date of Birth: _____

First Name: _____ _____ Date of Birth: _____

Parent Name: _____ Parent Name: _____

Address: _____ Address: _____

City, State, Zip: _____ City, State, Zip: _____

Home Phone: _____ Home Phone: _____

Cell Phone: _____ Cell Phone: _____

Occupation: _____ Occupation: _____

Work Number: _____ Work Number: _____

Email: _____ Email: _____

Name of Insurance: _____ Effective Date: _____

Subscriber Name & Policy ID #: _____

Subscriber Date of Birth: _____ Social Security #: _____

Employer: _____

Employer Address: _____

I hereby authorize WESTON PEDIATRIC PHYSICIANS, P.C., and the treating physicians to release any information required for the processing of insurance claims. I also authorize payment directly to said physicians for benefits, if any, otherwise payable to me for their services. I understand that if one of the providers at WESTON PEDIATRIC PHYSICIANS, P.C., is not listed as my child(ren)'s primary care physician I will be responsible for all charges incurred without a referral. I understand I am financially responsible for all charges not covered by this authorization and guarantee payment of the account.

Signed: _____

(Patient or Parent if minor) (Date)

*Revision: October 2014*