Welcome to
HUNT CLUB PEDIATRICS ASSOCIATES, LLC
Your Home for exceptional Pediatric Healthcare

425 S Hunt Club Blvd, Suite 1051 Apopka, FL 32703
Phone: 407.786.4080
Fax: 407.786.4667

Patient Authorization Signature

Your Children's Name

Name:_____ DOB:_____ Gender:_____

Name:_____ DOB:_____ Gender:_____

Name:_____ DOB:_____ Gender:_____

Financial Responsibility

_____ **Initials** **I have received a copy of Hunt Club Pediatrics Financial Policy statement. I understand coverage is not a guarantee of payment, and I agree that I am ultimately responsible for payment for services rendered at Hunt Club Pediatrics. I am responsible for any health Insurance co-payments, Deductibles and remaining balance not covered by my insurance company. I understand that Hunt Club Pediatrics is not responsible for knowing what services my plan covers and does not cover.**

Insurance Responsibility

_____ **Initials** **I irrevocably assign and transfer to Hunt Club Pediatrics Associates, LLC, all insurance benefits covered to Hunt Club Pediatrics Associates, LLC services for payment of services rendered. I understand it is my Responsibility for providing a current copy of my insurance card and notifying Hunt Club Pediatrics of Any changes/addition to patient's insurance coverage.**

Authorization for Release of Information

_____ **Initials** **I hereby authorize Hunt Club Pediatrics to release necessary information for the following reasons: to Other physicians for continuing professional care; to any insurance company or their representatives, or Otherwise as allowed by law. I release Hunt Club Pediatrics from any liability for the release of Information, and I understand that release includes all blood and related tests, Including HIV, HIB and other diseases. This authorization is irrevocable and is not limited in time.**

Authorization for Care/Treatment