

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

Assignment of Benefits

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

Address: \_\_\_\_\_ Home Phone : \_\_\_\_\_

\_\_\_\_\_ PCP: \_\_\_\_\_

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: \_\_\_\_\_

Social Sec #: \_\_\_\_\_ Social Sec #: \_\_\_\_\_

Name of Insurance: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Subscriber Date of Birth: \_\_\_\_\_

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)