COLUMBIA MIDTOWN PEDIATRICS

JENNIFER KANGAS MD • LAUREN LEVINE MD

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TEL 212.326.3352 • FAX 212.326.3355

Name of insured: _____

Health insurance ID#: _____

Commercial insurance:
I hereby authorize direct payment of medical benefits to Columbia University Westside Pediatrics for services rendered by the above-named physicians in person or under their supervision. I understand that I am financially responsible for any balance not covered by my insurance policy. I hereby authorize Columbia University Westside Pediatrics to release any medical or incidental information that may be necessary for either medical care or processing applications for financial benefits.

Patient's/Insured's signature: _____

Date signed: _____