



Authorization

*Please read carefully. Do not fill out this form.
You will be asked to sign on the computer when your child is checked in.*

1. I give lifetime authorization for my child's insurance benefits to be paid directly to Skyline Pediatrics Professional Corporation &/or Brice D. Kopas, MD. I understand that I am financially responsible for any non-covered services. In the event of default, I agree to pay all costs of collection and reasonable attorney's fees.
2. I authorize Skyline Pediatrics Professional Corporation to release any information required to process my child's insurance claims.
3. I authorize Skyline Pediatrics Professional Corporation and all of its physicians or employees to treat my child as needed per generally acceptable standards of care.
4. I acknowledge that I have reviewed a copy of the Skyline Pediatrics "Notice of Privacy Practices", and can receive a copy if I so desire.
5. I acknowledge that I have reviewed and agree to abide by Skyline Pediatrics "Financial Policy".