Hawthorn Medical Associates
An Affiliate of STEWARD HEALTH CARE NETWORK

Hawthorn Pediatrics

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DATE _____

PATIENT NAME _____

CHART # _____

I request that Medicare or other health care insurers make payment for authorized benefits for services furnished to me directly to Hawthorn Medical Associates.

I understand that I am responsible for any amount not covered by my insurance.

I further authorize the release to Medicare or other insurance carriers any information acquired in the course of my treatment necessary to process my medical claims.

Parent/Guardianship signature _____

Date _____