



Infants, Children & Adolescents

*Diplomates of the  
American Board of Pediatrics*

www.childrensmedgroup.com

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FISHKILL

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HYDE PARK

MODENA

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CEO

## RETURN TO PRACTICE

PATIENTS NAME: \_\_\_\_\_  
(Please Print)

D.O.B.: \_\_\_\_\_

ACCOUNT NUMBER: \_\_\_\_\_

My child is returning to The Children's Medical Group  
as of: \_\_\_\_\_

I have notified my insurance company that a provider at The Children's Medical Group will be my child's Primary Care Physician.

I agree to pay any bills that are incurred in the event that I have not notified my insurance company. This will be for all visits until we have confirmed coverage.

I will request that my child's records be transferred back to The Children's Medical Group. (Please fill out a separate form).

\_\_\_\_\_  
Parent's Signature

\_\_\_\_\_  
Date

3/21/07MP