Assignment and Release

I, the undersigned certify that I (or my dependent) have insurance coverage with

_____

and assign directly to Pediatric Care Associates all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Pediatric Care Associates to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I further agree to pay any collections and/or legal fees necessary for collection, if such situation was to arise. If I cancel an appointment less than 24 hours prior to the appointment time I will be charged a cancellation fee of $25.00.

_____ _____

(Responsible Party Signature) (Relationship)

Date _____

HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) protects patient privacy. Pediatric Care Associates complies with HIPAA and provides a Notice of Privacy Practices to patients to let them know how we disclose information to whom and under what circumstances, the rights of patients and methods of reporting complaints. Under the HIPAA guidelines we use information for payment, treatment and healthcare operations. For more information, consult the Notice of Privacy Practices.

Patient Financial Policy

Thank you for choosing Pediatric Care Associates as the healthcare provider for your child/children. We are committed to providing you with outstanding care at the most affordable cost. In order to achieve these goals, we need your assistance and your understanding of our financial policy.

FULL PAYMENT FOR PROFESSIONAL SERVICES IS DUE AT THE TIME SERVICE IS RENDERED IF YOU ARE WITHOUT INSURANCE COVERAGE (SELF-PAY).

ALL COPAYMENTS MUST BE MADE AT THE TIME OF CHECK-IN FOR THE APPOINTMENT. WE ACCEPT CASH, CHECK AND MAJOR CREDIT CARDS.

- I have enrolled my child/ren in my insurance plan. I understand by law that I have 30 days to add my newborn child to my policy and/or have a qualifying event. If my child/ren have not received a policy number within 30 days or less I am still responsible for all charges incurred.
- As a courtesy, upon presentation of your current valid insurance card we will bill your insurance carrier. However, the entire balance is your responsibility whether the insurance company pays or not. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract.
- The adult accompanying a minor child is responsible for co-payment in full at the time services are rendered.
- Pediatric Care Associates is authorized to receive direct payment of any medical benefits for the services being rendered.
- In the event that your insurance coverage changes to **a plan in which we are a non-participating provider,** you are responsible for payment in full at the time service is rendered. We will provide you with the necessary medical documents in order to process your claim upon request.
- A Pediatric Care Associates physician must be listed on your child/ren's insurance card as their **primary care physician** in order for us to receive reimbursement for services rendered. It is your responsibility to assign the correct primary care physician through your healthcare plan. Any services denied reimbursement due to the **primary care physician** will be your responsibility.
- It is your responsibility to make sure the dependent information on the insurance card reflects the correct spelling of your child/ren's name(s) as well as the assigned **primary care physician.** If we verify your insurance and find out the coverage is not valid or the policy has been terminated, all services rendered to your child/ren must be paid in full at the time of service.
- We reserve the right to charge a $25.00 Insufficient Funds ***(ISF)*** Fee for any returned items (checks and/or credit/debit card transactions).

By signing below, I agree that I have read and understood the above mentioned terms and conditions of the financial policy for Pediatric Care Associates.

Guarantor's Signature / Responsible Party Date

Staff Member's Signature / Printed Name Date