RELEASE, ASSIGNMENT, AND FINANCIAL RESPONSIBILITIES

I acknowledge that my insurance may not cover all services requested by parent or physician. I acknowledge that my insurance carrier may process my claims with deductibles, co-insurances, and co-payments. I also acknowledge and understand that newborns and dependents **must be added** to the insurance policy in order to be covered (time frame for newborn addition is dependent on your insurance carrier).

If a denial of payment is received from my insurance carrier the charge will become my responsibility. My financial responsibility explicitly includes “non-covered” services including, but not limited to:

- All immunizations
- Laboratory tests performed in the doctor’s office
- After-hours, weekend, and holiday visit charges
- Vision testing
- Hearing testing
- Physical exam – well child visits requested beyond allowances of insurer
- Development screening
- Visits and immunizations related to travel
- Preparation fee for forms, letters, and medical records

I authorize the release of any medical or other information necessary to process or appeal a claim with my insurance carrier. I authorize payment of medical benefits to PediatriCare Associates. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

I accept financial responsibility for any treatment I agree to or request, regardless of my insurance carrier’s responsibility or reimbursement. I acknowledge financial responsibility for services rendered during periods when ineligible for or not covered by my insurance.

If my account goes to collections, I am responsible for all fees incurred.

Signature of Parent/Guardian ________________________________ **Date** ______________

Child’s Name ____DOB ______________

Child’s Name ____DOB ______________

Child’s Name ____DOB ______________

Child’s Name ____DOB ______________

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Understanding Your Insurance Plan

Many parents of our patients have questions/concerns regarding their insurance coverage of certain services. Your health insurance policy is an agreement between you and your insurance company. Our office participates with many plans and each plan is underwritten between a person's employer and the insurance company. Therefore, **it is not possible for us to know what each individual insurance contract does and does not cover.** Insurance plans and what they cover can change from year to year and is based on each individual plan. No two plans are alike under insurance carriers.

PediatriCare Associate's fees are customary and reasonable. What we charge the insurance carrier is in line with what they reimburse. When PediatriCare participates with your insurance plan, we charge the insurance carrier a customary rate, but you are responsible for what the insurance states you are responsible for. Example: well care visit - $120 charged to insurance. Insurance processes and allows $90. $30 is adjusted off by PediatriCare as a contractual agreement between us and your insurance. See following examples of what your financial obligation may be.

Co-pays – as determined by your insurance carrier/employer contract. Carriers normally apply co-pays to the office code for sick visits; also can apply to well care visits. Under the National Healthcare Reform Act, insurance carriers are not allowed to charge a co-pay on the well care office code, but they are allowed to apply it to other services performed during the course of a well care check-up. Co-pays are your responsibility to pay.

Co-insurances – as determined by your insurance carrier/employer contract. Example – insurance allows $20 towards a service, pays $17.50, you are responsible to pay for $2.50 difference.

Deductibles – are determined by your insurance carrier. Under the National Healthcare Reform Act, certain well care diagnostic/screening procedures can be applied to deductible by the insurance. Example – your plan has a $2500 deductible per year. Insurance allows $156.70 for an office/well care visit and applies to deductible. You are responsible to pay $156.70.

Maximum Benefits – are determined by your insurance carrier. Example: $500 maximum allowed on well care visits per year. Insurance allows $750 towards well care visit charges, pays $500 and applies $250 to maximum benefits. $250 would be your responsibility.

The insurance company agrees to cover the cost of certain benefits listed in your policy. These are called "covered services". **Coverage does not guarantee full payment and your insurance company may require partial payment due by the policy holder.** Your individual policy also lists the kinds of services that are not covered by your insurance company. You are responsible for any uncovered medical care that you receive. Remember that your insurance company, not your provider or the physicians' office, makes decisions about what will be paid for and what will not. Some examples:

Hearing	Vision	Urinalysis
Developmental Evaluation	Gardasil	Pulse Oximetry
Flu Test	PKU	Tympanogram
After hours, weekend, & emergency office codes		Specimen Collection & handling

PediatriCare Associate's focus and concern is the health and well-being of our patients. Tests and evaluations done during the course of your child's well care visit are deemed necessary for the healthy development of your child.

I acknowledge that I have read and acknowledge the about information.

Signature of Parent/Guardian ______________________________________ **Date** ____________________

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