Pediatric Care Physicians

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Financial Responsibility Agreement

Dear Parent or Responsible Party:

Positive verification of your insurance cannot always be made at the time of your visit. Your child will receive services today with the understanding that in the event your coverage is not effective, you will be billed and held financially responsible for these services. **Additionally, you agree to be financially responsible for services provided that are not a covered benefit of your insurance plan. Copays and coinsurance are due at the time of the visit.**

Patient's Name_____

Date of Birth _____

Subscriber's Name_____

Subscriber's Date of Birth_____

Address _____

_____

Parent Cell (☐ Mom ☐ Dad) _____ Cell Service Provider_____

Parent Cell (☐ Mom ☐ Dad) _____ Cell Service Provider_____

Patient Cell _____ Cell Service Provider_____

I have read the above and understand the potential financial responsibility for services rendered during this current calendar year and hereby affix my signature in acknowledgement of this understanding.

Parent's Signature _____ Date _____

Receptionist _____

Parent's Signature _____ Date _____

Receptionist _____

Parent's Signature _____ Date _____

Receptionist _____

Parent's Signature _____ Date _____

Receptionist _____

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