Proof of Insurance Coverage Form

Please read the following statement carefully, then sign and date it.
We greatly appreciate your cooperation.

I understand that I must have proof of insurance coverage for my child after 30 days of age. If the insurance is an HMO, it must include proof that one of the pediatricians in the office is the Primary Care Physician (PCP).

If I have no proof of coverage for my child, I understand that I will have to pay in full at the time the service is provided.

If any of the information I have provided is incorrect or incomplete, I understand that I am responsible for paying for the services provided and will have to pay at the time of service until the correct information has been supplied to the Billing Department.

In addition, I agree to pay charges that may arise for the following:

- Completion of forms that are not required as part of direct health care delivery (i.e. school, camp, athletics, adoption).
- Copying medical records
- Well check ups that are not included in the American Academy of Pediatrics guidelines for preventative care (children with chronic diseases or on medication are an exception)
- Non-covered services and all associated services (i.e. vaccines not covered by insurance)
- Missed or cancelled appointments (without 24 hr. prior notice.)
- Administrative charge when the copayment is not paid at the time of service.

Signed: _____ Print Name: _____

Relationship to Patient: _____

Patient's Name: _____ Date: _____