COVENANT CARE Pediatrics

2019

Authorization and Financial Responsibility Form

Waiver of Financial Liability

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Initials

I, the undersigned, understand that payment for all services is due at the time of service. Responsibility and payment shall be that of the guardian bringing the child in for treatment. I understand that I am financially responsible for all charges whether or not paid by my insurance company and for any co-pay, deductible, co-insurance, or any other balance not paid by my insurance company. I understand that I am responsible for any costs incurred in the collection of patients account in case of default, including reasonable collection agency, attorney fees and/or court costs.

Financial Policies

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Initials

I have received a copy of the Financial Policies of Covenant Care Pediatrics, P.C. ("the Practice") and I understand and agree to said policies. I understand that it is my responsibility to notify the Practice of any changes in address or other contact information and any changes in insurance coverage and that payment for services shall be my responsibility if I fail to notify the Practice of my correct insurance information.

I understand that any practice administrative fees are my responsibility, as outlined in the financial policy. This includes fees which may apply for after-hours phone nurse, forms, missed appointments, collection agency fees or fees associated with the collection of a balance.

I understand that some services offered by the practice which are in the best interest of my child's health and/or customer service and convenience may not be covered by insurance companies. I understand that I will be informed of any of these charges before I agree to pay for these services.

HIPAA Notice of Privacy Practices

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Initials

I have received a written copy of the Notice of Privacy Practices from Covenant Care Pediatrics.

Pharmacy Records

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Initials

I authorize the Practice to obtain my child's medication history from prescription benefit management systems such as SureScripts.

ASSIGNMENT OF BENEFITS

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Initials

I hereby grant permission to the Practice to release any pertinent information to my child's insurance company or their agent. I hereby assign to the Practice any insurance or other third-party benefits available for health care services provided. I understand that the Practice has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to the Practice, I agree to forward to the Practice all insurance and other third-party payments I receive for services rendered immediately upon receipt. A photocopy of this authorization shall be considered as effective and valid as the original.

Signature of Responsible Party

Patient Names:_____

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Responsible Party Printed Name

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Signature of Responsible Party Date