

Pediatric Associates, PA

Financial Policy

I authorize **PEDIATRIC ASSOCIATES, PA:**

1. To obtain all medical information necessary to provide services
2. To receive assignment of benefits from any applicable government funded, privately insured, or employer self-funded health benefit program to this claim
3. To request payment and to obtain or release any medical information necessary for reimbursement (payment) under applicable government funded health programs, managed care plans and / or private insurance

I authorize any holder of medical or other information about me, to release to the Social Security Administration, the Centers of Medicare and Medicaid Services, their intermediaries or carriers, or to the billing agent or any other physician or supplier, any information needed for the payment of this claim or related claim.

I understand the fact that having insurance does not release me of my personal responsibility for payment. Further, I understand that, to the extent allowed under federal and state law or contracts with third-party payers, I may be billed or asked to make payment prior to services rendered for co-payments, co-insurance and deductibles due for medical services.

I understand that **PEDIATRIC ASSOCIATES, PA** will bill my insurance company as a courtesy to me. Further, I understand by signing this notice I acknowledge financial responsibility for services not paid by the insurance carrier.

I permit a copy of this authorization to be used in place of the original, and request payment of medical benefits to **PEDIATRIC ASSOCIATES, PA.**

I understand that **PEDIATRIC ASSOCIATES, PA** will send me 3 bills as a courtesy and if I do not respond to these bills I could be turned over to an outside collection agency. And there will be a \$10.00 fee attached to each statement.

Signature of Personal Representative

Date