PALM BEACH PEDIATRICS

PATIENT'S FINANCIAL RESPONSIBILITY DISCLOSURE

Patient's Name: _____ DOB: _____

At the present time, _____ is my insurance carrier. I will inform Palm Beach Pediatrics of any changes with the above insurance carrier. I certify that I am not enrolled in any Health Maintenance Organization (HMO) or Preferred Provider organization (PPO) that is not contracted with Palm Beach Pediatrics.

As a courtesy, Palm Beach Pediatrics has agreed to file a claim for services rendered with my insurance carrier. I am responsible and expected to pay Palm Beach Pediatrics for the following:

1. Any co-payment as set by my insurance carrier
2. Any unsatisfied deductible or termination of coverage
3. Any amount my insurance carrier deems my responsibility
4. Any amount considered non-covered by my insurance carrier

If Palm Beach Pediatrics has not received payment from my insurance carrier within 30 days from the date of service, I may be expected to pay my balance in full. I am responsible to be sure that all charges are paid, whether by me or by my insurance carrier.

I understand that payment is required at the time services are rendered unless other arrangements have been made with the Billing Department in advance. Palm Beach Pediatrics accepts cash, personal checks, VISA, MasterCard, Discover and American Express. ** There is a $35.00 service charge for returned checks. **

I understand that I will be responsible for a "No Show" fee of up to $75.00 for not giving a 24 (twenty-four) hour advance notice of cancellation for any appointment I am unable to keep. This fee will be directly billed to me and not to my insurance company for payment. **Three No Shows will result in discharge from Palm Beach Pediatrics. **

I understand that I will be responsible for all collection costs, including legal fees and court costs should my account be referred to an attorney or collection agency. I further agree that once my account has been put into collections my child may not been seen until the balance is paid in full by me or by my insurance. ** Outside Collections may result in discharge from Palm Beach Pediatrics. **

PATIENTS NAME (PLEASE PRINT)	PATIENT'S SIGNATURE	DATE

As Parent/Guardian of the above referenced individual, I will continue to be responsible for all cost incurred for services rendered up to the age of 21.

PARENT/LEGAL GUARDIAN (PLEASE PRINT)	PARENT/LEGAL GUARDIAN SIGNATURE	SOCIAL SEC #	DATE

(561) 509-5009
www.pbpediatrics.com