FINANCIAL AND INSURANCE POLICIES

PLEASE INITIAL BELOW INDICATING THAT YOU HAVE READ, UNDERSTAND, AND AGREE TO ALL THE POLICIES CONTAINED ON THIS PAGE.

_____ I hereby authorize direct payment of medical benefits to Loop Pediatrics for services rendered by the physicians or the organization; I understand that I am responsible for any balances not covered by insurance

_____ Claims not paid within a timely manner (60 days) by my insurance company, become fully my responsibility.

_____ Full payment for all co-pays, deductible and non-covered services are expected at the time of your appointment. All other payment arrangements must be made with our billing department 24 hours prior to the appointment time

_____ A returned check penalty fee of $25 will be charged to a patient's account for any check dishonored by the drawee bank. This fee will be waived if the check was returned in error, providing supporting documentation is submitted. The returned check and penalty fee must be paid by cash, credit card or money order. If a returned check was used to pay for more than one patient, each patient will be assessed the $25 returned check fee. Payments made by a returned check are reversed from the patient's account, leaving the balance due and payable immediately

_____ I am responsible for requesting any necessary referrals prior to seeing any specialists, and prior to having any tests or procedures performed. When possible these requests should be made 2 days prior to the appointment date wit the specialist. It is up to the discretion of a Loop Pediatrics provider whether or not to issue a referral requested after the appointment or procedure date.

_____ Referrals are not a guarantee of insurance benefits or payment. Concerns regarding denial of payment for ordered tests, procedures or visits to third party providers are to be directed to your insurance carrier.

_____ I hereby authorize Loop Pediatrics to release any medical or incidental information that may be necessary to either medical care or in processing for financial benefits.

_____ I certify that the information given by me in the applying for payment under title XVII of the Social Security act is correct. I authorize any holder of medical or other information about myself to release to the social security administration or the intermediaries of carrier's any information needed for this or a related Medicare/Medicaid or other insurance claim. I hereby assign, transfer and set over to the physicians or organization furnishing the services all of my rights, title and interest of my medical reimbursement benefits under my insurance policy with any and all insurance companies, I permit a copy of this authorization to be used in place of the original.

_____
DATE

_____ _____ _____
SIGNATURE OF PARENT/LEGAL GUARDIAN PRINT NAME OF PARENT / LEGAL GUARDIAN PRINT NAMEOF PATIENT