Gold Coast Pediatrics

Financial Responsibility Form

I agree to pay all amounts for which I am financially responsible, in accordance with the rates and terms of Gold Coast Pediatrics, for services provided. I understand that to the extent permitted by law, where my insurer, third party payer or benefit plan are insufficient to pay for all the services rendered, that I will be responsible for the payment of balances due including deductibles, copayments or other fees required by the insurer, third party or benefit plan. I understand that if I have not provided Gold Coast Pediatrics with accurate and current information regarding my insurer, third party payer or benefit plan, I will be responsible for all care, treatment and services provided by Gold Coast Pediatrics. Should the account be referred to collection, I shall pay all reasonable fees and expenses.

I understand that I am responsible for

- ✓ Providing Gold Coast Pediatrics with verification of my current health insurance coverage.
- ✓ Informing Gold Coast Pediatrics immediately of any change in my insurance coverage, address or phone number
- ✓ Paying all copayments before leaving the office
- ✓ Paying in full for any medical services, lab tests, and immunizations that are not covered by my insurance plans.

Assignment of Benefits:

- ✓ I authorize Gold Coast Pediatrics to file insurance claims on my behalf for services rendered to my child or me
- ✓ I authorize all information regarding my benefits under any insurance policy relating to claims by Gold Coast Pediatrics to Gold Coast Pediatrics
- ✓ I irrevocably assign to Gold Coast Pediatrics, all my rights and benefits under any insurance contracts for payment for services rendered to me or my child by Gold Coast Pediatrics and direct that all payments go directly to Gold Coast Pediatrics
- ✓ I authorize Gold Coast Pediatrics to report any suspected violations of proper claims practices to the proper regulatory authorities
- ✓ I understand that my financial liability will be determined by the provisions of my benefit plan

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However, I hereby attest that I am financially responsible for any charges resulting from my decision to do the following:

- ✓ If I choose to see an out-of-network provider without an authorization from the benefit plan's utilization management
- ✓ If I choose to use an out-of-network facility without authorization from my benefit plan's utilization management
- ✓ If I choose to see an in-network specialist without an authorization referral from my benefit plan's primary care physician
- ✓ If I choose to have a service/procedure performed that is not covered by my benefit plan

_____ _____

Signature of Parent or Guardian Date

_____

Print Name

I, _____, a parent or legal guardian of :

List Child(ren) Name(s):

_____

_____

_____

_____

I have received the Pediatric Healthcare of LI Notice of Privacy Practice. I have been informed that should I have questions regarding Gold Coast Pediatrics Policy or do not understand information in the Notice that I may direct these questions to the privacy officer

_____ _____

Signature of Parent or Guardian Date: