



PATIENT'S FINANCIAL RESPONSIBILITY DISCLOSURE
(Please read carefully)

Patient Name: _____ Date of Birth: _____

At the present time, _____ is my insurance carrier. I will inform Palm Beach Pediatrics of any changes with the above insurance carrier.

As a participating physician with my insurance carrier, Palm Beach Pediatrics has agreed to file a claim for services rendered. I will be responsible 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

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.

****I understand that I will be responsible for the \$25.00 fee incurred for not giving 24 (twenty-four) hours advance notice of cancellation of any appointment I am unable to keep. This fee will be directly billed to me and not to my insurance company for payment.**

I further agree that I will be responsible for all collection costs, including legal fees and court costs should this matter referred to an attorney or collection agency.

I HAVE READ THE ABOVE INFORMATION AND AGREE TO BE FINANCIALLY RESPONSIBLE FOR SERVICES RENDERED BY PALM BEACH PEDIATRICS.

Patient's 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's signature

Date