



**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. 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 45 days of 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 in advance. Palm Beach Pediatrics accepts cash, personal checks, VISA, MasterCard, Discover and American Express. *There is a service charge for returned checks.*

I understand that I may be subject to a **"Late Fee"** of \$10.00 per month if my account balance is not paid within 30 days of receipt of my first statement.

I understand that I will be responsible for a **"No Show"** fee of up to \$50.00 if 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. **\*\*Excessive abuse of scheduled appointments may result in discharge from Palm Beach Pediatrics. \*\***

I further agree 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 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/Guardian Signature**

\_\_\_\_\_  
**Date**