Building Blocks Pediatric Group, LLC

Assignment of Benefits
Responsibility and Authorization for Treatment
Release of Information

I authorize payment for the services rendered and assign my rights and benefits under contracts for payment from my insurer to Building Blocks Pediatric Group, LLC. I certify that the information I have provided in applying for payment under my insurer is correct. I authorize that any medical or other personal information needed for a claim be released to my provider. I also request that payment of benefits on my behalf be made to Building Blocks Pediatric Group, LLC for services rendered. I understand that this agreement is effective until revoked, and that I agree to pay any co-pay or deductible that is my responsibility as per my insurance carrier.

In the event that I receive a check for services rendered by Building Blocks Pediatric Group, LLC, I agree to endorse the check to Building Blocks Pediatric Group, LLC and deliver the original check to them. I also understand that if the provider does not receive payment from the insurance company, I am personally responsible for the provider's charges.

I hereby authorize Building Blocks Pediatric Group, LLC to release any pertinent medical records upon written request to the insurance provider. Furthermore, I understand that I have a right to inspect or copy any medical records to be used or disclosed, and that I also have the right to refuse to sign this authorization.

Parent/Guarantor Signature _____ Date _____

Financial Responsibility Statement

Thank you for choosing Building Blocks Pediatric Group, LLC as your healthcare provider. By accepting our services you have agreed to a financial responsibility on your part, ensuring full payment of our fees. We will always verify your coverage and bill the appropriate insurance carrier for the services provided. However, you are ultimately responsible for the payment of your bill and balance. As part of this agreement, you are responsible for any deductible or co-pay as determined by your insurance carrier. These payments must be made at the time of service. Overall, you are responsible for any amount not covered by your insurance. If for any reason you or your physician elect to continue past your approved period (lapse in insurance coverage), you will be responsible for your balance in full. We reserve the right to delay service until your balance is paid in full.

I have read the above policy regarding my financial responsibility to Building Blocks Pediatric Group, LLC, for the services rendered. By signing below, I authorize my insurer to pay any benefits for the full and entire amount of bill directly to Building Blocks Pediatric Group, LLC on my behalf.

Guarantor Signature _____ Date _____