FINANCIAL RESPONSIBILITY AGREEMENT

Patient Name:_____ DOB:_____

I understand and agree that I will be financially responsible for any and all charges for services rendered or not paid by my insurance. This includes any medical service or visit, preventative exam/physical, lab or diagnostic testing, and any other screening service ordered by the physician or the physician's staff.

I understand and agree that it is my responsibility and not the responsibility of the physician or staff to know if my insurance will pay for such medical service(s), preventative exam/physical, lab or diagnostic testing, or any other screening service ordered by the physician or the physician's staff.

I understand and agree that it is my responsibility to know if my insurance has any Deductible, Co-Payment, Co-Insurance, Out-of-Network, Usual and Customary Limit or any other type of benefit limitation for the services I receive and I agree to make full payment.

I understand and agree that it is my responsibility to know if the physician that I am seeing is a contracted in-network provider recognized by my insurance company or plan. If the physician I am seeing is not, it may results in claims being denied or higher out of pocket expense to me and I understand this and agree to be financially responsible and make full payment.

I understand and agree that it is my responsibility to know if my PCP choice has been processed by my Insurance Company or plan. If I have requested a PCP change that is not processed by my insurance company, it may result in claims being denied and I understand this and agree to be financially responsible and make full payment.

I hereby authorize payment of medical benefits directly to Pediatric & Adolescent Specialists of Rockwall for services rendered. Authorization is hereby granted to release information contained in my medical record to my insurance company or its employees/agents as may be necessary to process and complete my medical insurance claim(s). I further understand should my account become delinquent, I shall pay the reasonable attorney fees or collection expenses, if any. The duration of this authorization is indefinite and continues until revoked in writing.

Signature:_____ Date:_____

Print Responsible Party Name:_____