

Date: \_\_\_\_\_

**Our office files insurance claims as a courtesy. In order to extend this courtesy, it is necessary that we receive all information requested, including the insured's social security number.**

Patients should remember that professional services are rendered and charged to the patient and not the insurance company. We cannot accept responsibility for collecting your insurance claims or for negotiating a settlement on a disputed claim. Regardless of the action of your insurance company, you are responsible for your bill. Co-payments, co-insurance, and deductibles are due at the time of service. Balances may not, at any time exceed \$400.00.

ASSIGNMENT AND RELEASE: I hereby authorize Memphis Pediatrics, PLLC to furnish information to insurance carriers concerning treatment, and I hereby assign to the doctor all insurance benefits otherwise payable to me for these services. I understand that I am financially responsible for all charges not covered by my insurance. I also understand that I am responsible for all reasonable collection costs and/or attorney fees incurred for the collection of this account. I agree to follow all office policies set by Memphis Pediatrics. I agree to provide any information requested by Memphis Pediatrics Staff concerning my account. I also understand that the information provided by me will be provided to Memphis Pediatrics' outside collection agency should my account become past due by 90 days or 3 billing statement cycles for collection procedures. I hereby agree that I am responsible for all collection costs and/or attorney fees in connection with collection of a balance for a past due account.

This form will remain in effect for 1 year from the date signed or until any information on this form/account changes, at which time I agree to fill out a new form with the correct information without delay. I also agree to provide new insurance cards upon receipt. I understand that if I delay in providing new insurance information my claims may be denied for timely filing limits and that I will be solely responsible for the affected charges. I understand that it is my responsibility to provide proper information to Memphis Pediatrics for filing my insurance. If I fail to provide accurate and complete information immediately I accept responsibility for payment of all services performed by Memphis Pediatrics.

**By signing hereunder I understand and agree that I am responsible for payment of services rendered by Memphis Pediatrics, PLLC for my children. I agree that, if my insurance company has not paid for services rendered within 60 days from the date of service I will pay said fees and work with my insurance company for reimbursement. I also understand that my insurance company may arbitrarily choose to deny some services as "non covered" and that I am responsible for those charges as well.**

I hereby acknowledge receipt of a copy of this policy and agree to the terms contained herein.

Responsible Party Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Date: \_\_\_\_\_