Rainbow Pediatrics

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Patient Name: _____ Date of Birth: _____

ASSIGNMENT OF BENEFITS

I request that payment of authorized benefits be made on my behalf to Rainbow Pediatrics for any services furnished the patient listed above by Rainbow Pediatrics physicians and health care providers, and I assign my right to receive these payments to Rainbow Pediatrics. I authorize Rainbow Pediatrics or any holder of medical information about me or the patient listed above to release my Health Insurance Plan such information needed to determine these benefits or the benefits payable for related services. If my Health Insurance Plan will not direct payment to Rainbow Pediatrics, I agree to forward to Rainbow Pediatrics all health insurance payments, which I receive for the services rendered by Rainbow Pediatrics and its health care providers.

OTHER HEALTH INSURANCE

I certify that the Insurance Information that I have provided is accurate, complete, and current and that no other coverage or Insurance exists.

PATIENT RESPONSIBILITY

I acknowledge that I am responsible for all charges for services provided to the patient listed above which are not covered by my Health Insurance Plan or for which I am responsible for payment under Health Insurance Plan. To the extent no coverage exists under my Health Insurance Plan or as otherwise permitted by law, I acknowledge that I am responsible for all charges for services provided and agree to pay all charges not covered by insurance.

Rainbow Pediatrics Financial Policy

We are doing everything possible to hold down the cost of medical care. You can help a great deal by eliminating the need for us to bill you. The following is a summary of our payment policy.

ALL PAYMENT IS EXPECTED AT THE TIME OF SERVICE

Deductible must be paid at time services are rendered.

Payment is required at the time services are rendered unless other arrangements have been made in advance. This includes applicable coinsurance and copayments for participating insurance companies. Rainbow Pediatrics accepts cash, personal check, VISA, MasterCard, Discover, and American Express. There is a service charge for returned checks.

Patients with an outstanding balance of 30 days overdue must make arrangements for payments prior to scheduling appointments or Rainbow Pediatrics will refuse to see me as a patient.

The outstanding balance has to be paid in 30 days after receiving statement from Rainbow Pediatrics.

Rainbow Pediatrics will refuse to see patients with outstanding balances.

I understand that there is a $15 fee for CD medical records and that I am responsible for paying any balance owed before records are sent.

INSURANCE:

We bill participating insurance companies as a courtesy to you. You are expected to pay your deductible and copayments at the time of service. If we have not received payment from your insurance company within 45 days of the date of service, you will be expected to pay the balance in full. You are responsible for all charges.

IF YOUR INSURANCE IS INACTIVE ON DATE OF SERVICE THEN YOU HAVE TO PAY FOR THE VISIT BEFORE BEING SEEN.

WALK IN PATIENTS:

We provide medical care for patients who walk in or call in same day, depending on the doctor's schedule, **but scheduled appointments will be seen first.**

REFUNDS:

Overpayments will be refunded upon written request to the responsible party within 30 days.

MANAGED CARE:

If you are enrolled in a managed care insurance plan (i.e., HMO); you must receive a referral from our office ***before*** seeing a specialist. **NO retroactive referrals will be given.**

WELL CHECKS/VACCINATIONS:

Parent/legal guardian **must** be present for well check visits that include vaccinations, unless written parental consent has been given authorizing another person.

MISSED APPOINTMENTS/ LATE CANCELLATIONS:

Broken appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. **Cancellations are requested 24 hours prior to the appointment.** We reserve the right to charge for missed or late-cancelled appointments. Excessive abuse of scheduled appointments may result in discharge from the practice.

MORE THEN 3 NO SHOWS FOR PHYSICAL APPOINTMENTS WILL RESULT IN TERMINATION FROM RAINBOW PEDIATRICS.

Rainbow Pediatrics reserves the right to terminate patient if they don't follow medical advice given by doctor and don't show up for follow up appointments.

I have read and understand Rainbow Pediatrics Financial/Office Policy. I understand that I am financially responsible for all the charges whether or not paid by my insurance carrier.

_____ _____

Signature of insured or authorized representative (parent/legal guardian) Date

Patient Name: _____ Date of Birth: _____