Patient Agreement

Please initial each item

_____ **INSURANCE PLANS:** I understand it is my responsibility to confirm with my insurance company that the physician/provider is currently under contract with m plan or be willing to be seen under "out of network" benefits.

_____ **COVERAGE:** I acknowledge that Be Pediatrics is not responsible to know what services my insurance covers. I shall direct questions regarding heath insurance policy coverage to my insurance company.

_____ **FINANCIAL COMMITMENT:** I agree to be responsible for all copays, deductibles, and non-covered services determined by my insurance plan at the time of my visit. If I do not have a copay or have not come prepared to pay past due balances, my child's appointment may be rescheduled for a later time. Furthermore, I understand that if someone other than me is bringing my child to Be Pediatrics, they will be responsible to pay for copays and any past due balances.

_____ **DEMOGRAPHIC VERIFICATION:** I am aware that I will be asked to verify insurance and demographic information so records remain current.

_____ **NO INSURANCE AT THE TIME OF SERVICE:** If proof of insurance coverage cannot be determined at the time of service, I understand that payment is required prior to services being provided and I will not be billed.

_____ **PAYMENTS:** I will promptly pay all amounts that have been determined my responsibility by my insurance carrier upon receipt of my statement. Any balance remaining after my health insurance processes a claim is my responsibility.

_____ **SERVICE FEES:** I understand my account will be charged $30 for non-sufficient funds/returned checks.

_____ **FORM FEES:** I understand that Be Pediatrics charges for forms that are not requested at the time of my visit. I am also aware that for letters written on company letterhead, the practice will charge a per letter fee according to the Form Fee policy.

_____ **APPOINTMENTS/LATE ARRIVALS:** I understand that it is important to arrive on time for my appointment. I am also aware that if I arrive more than 20 minutes past my scheduled appointment time, the practice may have to reschedule my appointment.

_____ **NO SHOWS:** I commit to give Be Pediatrics at least 24 hours notice if I am unable to keep my scheduled appointment. I understand if I miss 3 appointments in a 12 month period without notifying the practice, the Be Pediatrics will no longer be able to provide pediatric and adolescent healthcare services to my family.

_____ **MINORS:** If my child is not accompanied by a legal guardian, I agree to provide written authorization for medical treatment so that treatment can be rendered. I also agree to be available by telephone in the event that the physician/provider needs to contact me.

I have read and agree to the above financial and office policies. I understand that non-compliance with these policies may result in dismissal of my family from Be Pediatrics.

Patient Name:_____ **DOB:**_____

Patient Name:_____ **DOB:**_____

Patient Name:_____ **DOB:**_____

Legal Guardian's Signature: _____ **Date:**_____