PAYMENT POLICY FOR SERVICES RENDERED

Patient Name: _____

DOB:_____

- **If You Have Health Insurance:** Please **Initial** the Line Next Your Insurance in **Section 1 Or 2**.
- **If You Do Not Have Health Insurance**: Please Read **Section 3**.
- **Everyone:** Please S**ign** at Bottom of Form and give your card (if applicable) to the Receptionist so we may make a copy for your file.

1. **IF YOU HAVE INSURANCE WITH ONE OF THE FOLLOWING INSURANCE COMPANIES**, please initial the appropriate line. We will bill these companies directly and will follow up on outstanding balances. You will be responsible for payment of your designated co-pay at each visit to the office BEFORE you see the doctor. You are responsible to present updated referral authorizations from your insurance carrier when required.

_____ Aetna	_____ BCBS	_____ The Care Network
_____ Cigna	_____ Coventry/First Health	_____ Devon Health
_____ Humana	_____ Medicaid	_____ Medicare
_____ Memorial Health Partners	_____ Multiplan/PHCS	_____ Paragon
_____ Tricare	_____ United Healthcare	_____ Wellcare

2. IF YOU HAVE COVERAGE WITH INSURANCE COMPANY, NOT LISTED ABOVE. If you provide us with a copy of your card, we will submit a claim directly to your insurance company for reimbursement as a courtesy. Please review the following procedure and sign.

"I understand that my services are being billed directly to my insurance carrier for me. The insurance company should send payment directly to me (the patient). If the payment is received at our office the payment will be forwarded to the patient. I understand that it is my responsibility to follow up with my insurance company. I understand that this entire balance is at all times my responsibility."

Insurance Co Name: _____ Signed: _____ Date: _____

3. IF YOU DO NOT HAVE HEALTH INSURANCE, you are responsible for payment of your bill at the time of your visit. We accept personal checks, credit cards, and cash. A payment for the full services expected is due before your visit. If additional services are deemed medical appropriate during the course of treatment, the balance will be due when your visit is complete. If your bill exceeds $200.00, a payment plan can be worked out at the time of the visit.

"I understand and agree that regardless of my insurance coverage, I am responsible for the balance of this account for any professional services rendered. I certify that the above information is true and correct to the best of my knowledge. I will notify the office of any changes in my insurance status. I also agree that if I am unable to pay my bill promptly, I will call the billing department to make timely payment arrangements. I understand that if my account becomes delinquent and the Be Pediatrics incurs any collection charges, they will be my responsibility."

If the patient is a minor: **"By consenting to care at the, Be Pediatrics I am agreeing that I will take responsibility for the payment of the medical bills. I will provide the office with all information necessary and will communicate with the office regarding any changes in responsibility.**

Patient or Guardian Signature_____ **Date**_____