Pinecone Pediatrics
Statement of Patient Financial Responsibility

Patient Name: _____ DOB: _____

Pinecone Pediatrics appreciates the confidence you have shown in choosing us to provide for your health care needs. The service(s) you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full. We DO NOT bill Medicaid policies as a secondary insurance.

I have read the above policy regarding my financial responsibility to Pinecone Pediatrics, for providing services to me or the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Pinecone Pediatrics, the full and entire amount of bill incurred by me or the above named patient; or, if applicable any amount due after payment has been made by my insurance carrier.

Co-Pay Policy

Some health insurance carriers require the patient to pay a co-pay for services rendered. It is expected and appreciated at the time the service is rendered for the patients to pay at EACH VISIT. Thank you for your cooperation in this matter.

Consent for Treatment

I hereby authorize Pinecone Pediatrics, through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate assessment and treatment procedures.

Cancellation / No Show Policy

We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to call 48-hours prior to canceling your appointment. No shows are subject to a $50.00 fee per missed appointment. Patients who arrive later than 15 minutes from their scheduled appointment time will be considered a no show and will be cancelled.

I understand if I no show for three appointments or cancel for a total of three appointments, I may be discharged from care.

The Practice will notify you in writing, via certified mail, if you are discharged from care.

I have read and understand the above information, and I agree to the terms described:

Parent/Guardian Name_____

Parent/Guardian Signature _____ Date _____

Self-Pay

I do not have health insurance and will be responsible for services rendered here at Pinecone Pediatrics. I agree to pay Pinecone Pediatrics, the full and entire amount of treatment given to me or to the above named patient at each visit.

Parent/Guardian Signature _____ Date _____

Non-Contracted Insurance Coverage

If Pinecone Pediatrics is not a contracted provider with my health care coverage, I understand that any balance will be my responsibility to pay in full at the time of service.

Parent/Guardian Signature _____ Date _____