



Healthy Kids

PEDIATRIC GROUP

Financial Policies Agreement *PLEASE INITIAL EACH LINE*

____ I have been informed that some insurance companies do not cover all services at 100%: for example; vision, hearing, and developmental screenings. If my insurance does not pay HKPG for the services performed I understand that any charges not covered will be my financial responsibility.

____ I understand that I am responsible for any co-pay due to HKPG at the time of service, I also understand I will be responsible for payment of services in full if I do not have health insurance coverage on the date of service.

____ I understand there is an additional charge sent to my insurance if I visit the office for an appointment at 5:00 pm and after, a weekend appointment, or come to the office on a holiday. This is CPT code serves to inform the insurance companies that HKPG is available to see patients after normal business hours.

____ I understand that if I miss my appointment time there may be a charge of \$50 if 24 hours notice is not given.

____ I understand there is a \$35 fee for returned checks from HKPG.

____ I agree to the above financial policies. In the event of default, I agree to pay all cost of collection and attorney's fees. I hereby authorize Healthy Kids Pediatric Group to release necessary information to secure the payment of benefits

Assignment of Benefits

The undersigned hereby authorizes the release of any information relating to treatment, healthcare options and all claims or benefits, submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits and for services to be rendered without obtaining my signature on each and every claim to be submitted for myself and or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim. I hereby authorize my insurance company(ies) to pay and hereby assign directly to Healthy Kids Pediatric Group all benefits, if any, otherwise payable to me for his/her services as described on the attached forms. I understand that even though Healthy Kids Pediatric Group has agreed to participate with my insurance, I am ultimately responsible for all charges related to my children's care.

Caregiver Print & Sign Below

Date

