PATIENT'S FINANCIAL RESPONSIBILITY DISCLOSURE

Patient Name: ____________________ Date of Birth: ___________________

At the present time, _____________________________ is my insurance carrier. I will inform Oceans Pediatrics of any changes with the above insurance carrier.

As a courtesy, Oceans Pediatrics has agreed to file a claim for services rendered with my insurance carrier. I am responsible and expected to pay Oceans Pediatrics for the following:

1. Any co-payment as set by my insurance carrier
2. Any unsatisfied deductible or termination of coverage
3. Any amount my insurance carrier deems my responsibility
4. Any amount considered non-covered by my insurance carrier

I understand that payment is required at the time services are rendered unless other arrangements have been made in advance. Oceans Pediatrics accepts cash, personal checks, VISA and MasterCard. There is a service charge for returned checks.

I understand that I may be subject to a "Late Fee" of $10.00 per month if my account balance is not paid within 30 days of receipt of my first statement.

I understand that I will be responsible for a "No Show" fee of up to $25.00 if incurred for not giving 24 (twenty-four) hours advance notice of cancellation of any appointment I am unable to keep. This fee will be directly billed to me and not to my insurance company for payment.

I further agree that I will be responsible for all collection costs, including legal fees and court costs should my account be referred to an attorney or collection agency.

I HAVE READ THE ABOVE INFORMATION AND AGREE TO BE FINANCIALLY RESPONSIBLE FOR SERVICES RENDERED BY OCEANS PEDIATRICS.

________________________________ ___________________________________

Patient's Name (please print) Patient's Signature/Date

As Parent/Guardian of the above referenced individual, I will continue to be responsible for all cost incurred for services rendered up to the age of 21.

____ ___________________

Parent/Guardian Signature Date