Pediatric Pulmonary Associates
Education. Trust. Availability. For every child.

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AUTHORIZATION TO RELEASE INFORMATION, ASSIGNMENT OF MEDICAL BENEFITS AND AUTHORIZATION TO TREAT

Pediatric Pulmonary Associates, P.C. is contracted with many insurance plans. Some insurance companies require an appropriate referral in order for you visit to be a covered benefit. It is your responsibility to obtain this referral. If you are seen as a patient without the necessary authorization and eligibility, you are liable for any charges incurred.

Co-payments and deductibles are expected in full at each visit prior to being seen. If you are not prepared to make this payment at the time of your appointment, you will be rescheduled. We will bill the remaining balance to your insurance company.

After insurance payment is received, you are expected to pay the remaining balance in full within 30 days of the statement date, unless alternate arrangements are made with the billing department. If you fail to make payments as described above, your account will be sent to a collection agency. Any fees incurred will be your responsibility and you will be terminated from the practice.

You are responsible to verify our current participation with your insurance company.

We request at least 24 hours notification if you are unable to make your scheduled appointment. Failure to notify our office will result in a $50 no show fee.

This form authorized Pediatric Pulmonary Associates, P.C. to release medical information requested by your insurance company to process your medical claim. It also authorized your insurance company to pay benefits directly to Pediatric Pulmonary Associates, P.C.

This form also authorized Pediatric Pulmonary Associates, P.C. to perform treatment on your child/foster child.

_____ _____

Patient Name Date

_____ _____

Signature of Responsible Party Relationship