

Buckingham Pediatrics
4870 York Road
Buckingham, Pa. 18912
(215) 794-3305

Patient Name: _____ Account: _____ DOB: _____

Parent Name: _____

Financial Responsibility Authorization

Note: If a service is not covered by your insurance or your insurance does not pay for services rendered below, you are responsible to pay. Your insurance may not cover all services, even healthcare that you or your health care provider have good reason to think you need.

Service	Reason Your Ins. May not Pay	Estimated Cost
Well Care Sick Visit Other Services	Buckingham Pediatrics is not listed as the PCP for this insurance policy.	
Well Visit	I have requested to be seen before the standard time of 1 year and 1 day for my routine annual visit. I accept full financial responsibility if this claim is denied.	
Well Care Sick Care	Your child has not been added to your policy as of _____	
Credit Card Information		Signature

Options: Check only one box. We cannot choose a box for you.

Option 1. I want the _____ service listed above. I may be asked to pay now, but I also want my carrier billed for an official decision for payment. I understand that if my insurance does not pay, I am responsible for payment. I can appeal to my insurance. If my carrier does pay, Buckingham Pediatrics will refund any payments made by me.

Option 2. I want the _____ service listed above, but do not want to bill my insurance. I do have to pay now as I am responsible for payment.

Option 3. I do not want the _____ service listed above. I understand with this choice; I am not responsible for payment.

Additional Information:

This notice gives our opinion, not an official decision from your carrier. If you have questions on coverage or billing, please contact your carrier directly. For Option 1 you are required to give your credit card information which will be used if denied by insurance.

Signing below means that you have received and understand this notice.

Signature

Date