Clinical Pediatric Associates
8355 Walnut Hill Lane Suite 105 Dallas, TX 75231
Phone: 214-368-3659

PATIENT FINANCIAL RESPONSIBILITY STATEMENT

Clinical Pediatric Associates files insurance claims for all services with primary insurances. Patients are billed for any remaining balance after insurance processes the claim. Any non-covered services are the financial responsibility of the patient. In the event that payment for a service performed is denied by the insurance carrier, it is the patient's responsibility to pursue action with their insurance carrier, as the policy is a legal contract between the patient and the insurance company. If a patient has no insurance coverage they are financially responsible for all charges incurred.

Please read and initial below confirming that you have been informed of our billing and filing policies:

Any co-payment/co-insurance and applicable deductible amounts are to be paid at the time of service unless other arrangements have been made with the office. ______

Upon receipt of patient payment, the remainder of the bill will be filed with insurance for direct payment to our office. ______

It is the patient's responsibility to provide current insurance information at each visit, and any changes to a current policy must be provided before being seen by the doctor. ______

If, by mistake, the insurance remits payment to the policy holder, payment is to be forwarded to the doctor from the patient. ______

Any amounts or services not covered by insurance are the responsibility of the patient. ______

Any changes to the patients billing address or contact information is to be provided by the patient as needed. ______

Any charges due from missed appointments, copying of records, or other billing fees are the responsibility of the insured/patient. ______

I have completed this form with accurate information. I have read and understand my obligations and responsibilities. I acknowledge that I am fully responsible for supplying correct insurance information, billing information, and payment of any services not covered or approved by my insurance carrier.

Patient(s) Name ____

Parent Name or Authorized Representative ______________________________

Signature ______________________________ **Date** __________________