8325 Walnut Hill ln ste225, Dallas, TX 75231
214-691-3535

PATIENT FINANCIAL RESPONSIBILITY STATEMENT

Pediatricians of Dallas, PA files insurance claims for all services with primary insurance. Patients are billed for any remaining balance after insurance processes the claim. Any non-covered services are the financial responsibility of the patient(s). If payment for a service performed is denied incorrectly by the insurance carrier, our billing department will appeal on your behalf. If after appeal the insurance carrier continues to deny claims, 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 the patient(s) 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 the insurance claims are paid and 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 charges due to missed appointments, copying of records, forms fees, after-hour calls 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.

Guardian/
Signature_____Date_____