

**FINANCIAL ASSIGNMENT AND AGREEMENT  
INFANTS AND CHILDREN, P.A.**

Patient Name: \_\_\_\_\_ Parent/Guardian \_\_\_\_\_

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the Physician and is NOT a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance, or other balance not paid by your insurance/HMO/PPO plan.**

**IN ORDER TO CONTROL YOUR COSTS, PAYMENTS FRO SERVICES RENDERED ARE EXPECTED TO BE PAID AT THE TIME OF SERVICE.**

1. **NON-COVERED SERVICES:** I understand that certain services are **NOT** covered by Medicaid, HMO's, PPO's, or other insurance companies. I agree to personally pay for any non-covered or denied services.
2. **I request that payment of** authorized Medicare/Medicaid/Insurance/HMO/PPO benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration, its agents, or any insurance carrier or plan I may have, any information needed to determine these benefits payable for related services.
3. **If my Insurance/Medicaid/HMO/PPO does not cover my care at Infants and Children, P.A., I agree to personally pay for all services rendered. I acknowledge that it is my responsibility to know my plan's coverage and inform Infants and Children, P.A. of any changes in coverage.**
4. This assignment will remain in effect until revoked by me in writing. A photocopy of the assignment is to be considered as valid as original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee, Infants and Children, P.A., to release all information necessary to secure the payment.
5. **IF NO INSURANCE: I Understand and agree that I am responsible for all charges incurred regarding my medical treatment and that I will make payment at the time of service.**
6. Account due after 30 days will be assessed a monthly fee of 1 ½% on the unpaid balance.
7. Any returned check will be charged the bank processing fee plus \$25.00
8. **NO SHOW POLICY: A \$25 fee will be charged for al broken appointments unless a 24 hour notice is given.**

Patient/Parent guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_  
(Printed Name)

For your convenience we accept:

**MasterCard, Visa, American Express, Check or Cash.**