Pediatric Healthcare
of Long Island

Assignment of Benefits Form

I irrevocably assign to Pediatric Healthcare of LI, all my rights and benefits under any insurance contracts for payment for services rendered to me or my child by Pediatric Healthcare of LI. In addition:

1) I authorize Pediatric Healthcare of LI to file insurance claims on my behalf for services rendered to my child or me.

2) I authorize all information regarding my benefits under any insurance policy relating to claims by Pediatric Healthcare of LI be released to Pediatric Healthcare of LI.

3) I direct that all payments go directly to Pediatric Healthcare of LI.

4) I authorize Pediatric Healthcare of LI to report any suspected violations of proper claims practices to the proper regulatory authorities.

5) I am responsible to name Pediatric Healthcare of LI or one of the physicians in the group as my Primary Care Provider. I understand that if I do not name Pediatric Healthcare of LI or one of the physicians in the group as my Primary Care Provider I am responsible for all fees not covered by my insurance carrier.

This assignment of benefits has been explained to my full satisfaction and I understand its nature and effect.

Signature of Parent or Guardian _____ Date: _____

Print Name _____Account #_____

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Financial Release Form

I understand that my financial liability will be determined by the provisions of my benefit plan. However, I hereby attest that I am financially responsible for any charges resulting from my decision to do the following:

1) If I choose to see an out-of-network provider without an authorization from the benefit plan's utilization management.

2) If I choose to see an in-network (participating) specialist without an authorized referral from my benefit plan's primary care physician.

3) If I choose to use an out-of-network facility without authorization from my benefit plan's utilization management.

4) If I choose to have a service/procedure performed that is not covered by my benefit plan.

Financial Agreement

Delinquent accounts will be submitted to a collection agency. Any collection fees will be the parent's or guardians responsibility. If we do not participate in your insurance, or you do not have insurance you must pay for your visit. We will charge $15.00 for any returned checks. We accept all major credit cards, checks and cash.

Signature of Parent or Guardian _____ Date: _____