Pediatric Healthcare
of Long Island

PHLI Financial Responsibility Form

PHLI accepts cash, checks and all major credit cards.

I understand that I am responsible for:

- ✓ Providing PHLI with verification of my current health insurance coverage.
- ✓ Naming a PHLI physician as my child's Primary Care Physician (PCP) and notifying my insurance company of my selection when that is required by my insurance company. 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, that I am responsible for all fees not covered by my insurance carrier.
- ✓ Informing PHLI immediately of any change in my insurance coverage, address or phone number.
- ✓ Paying all copayments before leaving the office. All copayments not paid for at the time of the visit will be assessed a $25.00 fee.
- ✓ Paying in full for any medical services, lab tests, and immunizations that are not covered by my insurance plan. If any non-covered procedures are recommended by a doctor at PHLI, I will be asked to sign a waiver indicating that I assume full financial responsibility for the cost of those procedures.
- ✓ Paying any balance from co-insurance, deductibles and non-covered services within 30 days of receiving a billing statement.
- ✓ All collection fees in addition to the outstanding balance, if my account is turned over to a collection agency.
- ✓ Paying a $30 fee for any returned checks.
- ✓ Paying a $50 fee for missing a well care appointment if I do not cancel at least 24 hours prior to my appointment time. PHLI will send a letter and waive this charge the first lime this occurs for a family.

Assignment of Benefits:

- ➢ I authorize Pediatric Healthcare of LI to file insurance claims on my behalf for services rendered to my child or me.
- ➢ I authorize all information regarding my benefits under any insurance policy relating to claims by Pediatric Healthcare of LI to be released to Pediatric Healthcare of LI.
- ➢ 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 and direct that all payments go directly to Pediatric Healthcare of LI.
- ➢ I authorize Pediatric Healthcare of LI to report any suspected violations of proper claims practices to the proper regulatory authorities.

- 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:

- ✓ If I choose to see an out-of-network provider without an authorization from the benefit plan's utilization management.
- ✓ If I choose to use an out-of-network facility without authorization from my benefit plan's utilization management.
- ✓ If I choose to see an in-network (participating) specialist without an authorized referral from my benefit plan's primary care physician.
- ✓ If I choose to have a service/procedure performed that is not covered by my benefit plan.

_____
Signature of Parent or Guardian Date: ____ / ____ / _____

_____
Print Name

Account # _____

I,_____, a patient, parent or legal guardian of:
(please print)
List Child(ren) Name(s):
_____
_____
_____
_____

Account Number: _____

have received Pediatric Healthcare of LI Notice of Privacy Practice. I have been informed that should I have questions regarding Pediatric Healthcare of LI Policy or do not understand information in the Notice that I may direct these questions to the Privacy Officer.

_____
Patient Signature

Date: _____ / _____ / _____

Please file in Medical Record on left side of chart with data sheet