PEDIATRIC ASSOCIATES OF DURANGO

Financial Responsibility

WHO IS THE FINANCIAL GUARANTOR? This is the person who will receive the billing statements in the mail. (Parents must agree on who is the financial guarantor. If there are any payment issues, they must be resolved between the parents. Pediatric Associates of Durango can not become involved with domestic arguments over who receives Billing Statements)

Name: _____Date of Birth: ____ / ____ /_____ SS#_____-_____-_____

Mailing Address:_____City:_____ State:_____ Zip:_____

Preferred Language: _____ E-mail:_____

Best Phone Number _____ Leave Message Y/N Alternative:_____ Leave Message Y /N

Relationship to Patient(s) _____ Do You Live with the Patient? _____Yes _____No

At Pediatric Associates of Durango no one will be denied access to services due to inability to pay. Please read the following information carefully and initial where indicated, acknowledging your understanding and acceptance of your financial obligations.

Initial ____I hereby authorize Pediatric Associates of Durango to release any information acquired in the course of my child's/ren's treatment necessary to process insurance claims.

Initial ____ I understand that it is my responsibility to confirm with my insurance company that the provider is currently under contract with my insurance plan, or be willing to be seen at "out of network" benefits. Any questions about medical, well baby/preventive care, labs/x-rays, and immunization coverage, should be directed to my insurance carrier **prior** to my visits. I agree to be held responsible for all co-pays, deductibles, and non-covered services as determined by my insurance plan.

Initial ____ If I have a co-payment, I agree to pay the full amount of the co-payment at the time of service.

Initial ____ I hereby authorize payment directly to the provider for services rendered for any benefits available under my insurance, and I am financially responsible for non-covered services rendered.

Initial _____I understand that during well child visits other issues may arise that are not covered by insurance under the definition of well-visit and therefore, there may be charges for these additional services.

Initial ____ I understand that if, 60 days after billing, I fail to pay any balance due on my account, further action may be taken, including asking for the assistance of an outside collection agency, unless previous arrangements to pay the outstanding balance have been made and approved by Pediatric Associates of Durango. If my account is sent to collections, I understand there will be additional fees associated with the collection process on top of the balance due.

Initial ____ I am aware that the individual hospital, provider, or lab I am **referred to** will bill me for that service and that Pediatric Associates of Durango has no control over this billing. This includes any pre-existing conditions. If there is a problem with this billing, I will contact the appropriate hospital, or other provider's office.

Initial ____ I agree to provide Pediatric Associates of Durango with a copy of my insurance card prior to or at my first visit and if my insurance coverage changes at any point in the future, agree to provide them with this updated information.

Initial ____ I understand I can elect to Self Pay. If I pay the **full amount on the day of service**, a discount will be applied for services, **not** including any labs sent out from the clinic. **If I choose to pay over time, this discount will not be applied.** I further understand Pediatric Associates of Durango offers a Sliding Fee program based on Federal Poverty Guidelines using Family Size and Household Income as defined by the Census Bureau. Proof of income is required and participation in the Sliding Fee Program must be approved by Pediatric Associates of Durango.

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Signature of Financial Guarantor Date