Pediatric Associates of Montgomery County

Assignment of Insurance Benefits
Acknowledgement of Receipt of Notice of Privacy Practices

Updated 07/17/2017

Patient Name:_____ **Date of Birth:_____**

Assignment of Insurance Benefits:
I hereby authorize the release of pertinent medical information to insurance carriers and authorize my insurance benefits to be paid directly to Pediatric Associates of Montgomery County, PA, realizing that I am responsible to pay unpaid services. The medical services will be submitted to my insurance company based on the information I have provided. If payment has not been received within 60 days of service OR payment has not been received due to incorrect insurance information being given to PAMC at time of service, the charges become my responsibility and will be due in full at that time. Outstanding or unpaid patient portion balances greater than 60 days will be assessed a 12% annual finance charge including outstanding insurance balances. I understand the billing practice of Pediatric Associates and will personally guarantee to cover any charges that my insurance company state they do not cover or that I am responsible to pay for regarding the medical care rendered to my child(ren).

X _____

Signature of Patient (or Parent if a Minor) Date

Acknowledgement of Receipt of Notice of Privacy Practices:
Pediatric Associates participates in CRISP, the Maryland State Health Information Exchange. Providers may provide and obtain medical information from the Health Information Exchange. You may opt out of this service. We can provide you with a copy of the opt-out form, but if you wish to opt out, you must send the form directly to CRISP.

A Health Information Exchange, or HIE, is a way of sharing your health information among participating doctors' offices, hospitals, care coordinators, labs, radiology centers and other healthcare providers through secure, electronic means. The purpose is so that each of your participating healthcare providers can have the benefit of the most recent information available from your other participating providers when taking care of you. When you opt out of participation in the HIE, doctors and nurses will not be able to search for your health information through the HIE to use while treating you. Physicians and other treating providers will still be able to select the HIE as a way to receive your lab results, radiology reports and other data sent directly to them that they may have previously received by fax, mail or other electronic communications.

I hereby acknowledge receipt of *Notice of Privacy Practices* of Pediatric Associates of Montgomery County.

X _____

Signature of Patient (or Parent if a Minor) Date

Acknowledgement of Payment Policies:
I understand that payments for office visits are due at the time services are rendered unless prior arrangements have been made. Additionally, I understand that I will be billed $35.00 for any returned check presented to the office for payment. No show fee(s) of $35.00 will be billed to me, not my insurance company, whenever applicable.

I hereby acknowledge the payment policies of Pediatric Associates of Montgomery County.

X _____

Signature of Patient (or Parent if a Minor) Date