Cumming Pediatric Group

Patient Name:________________DOB:___/___/______

It is our policy to inform you of our patient payment procedure. Please review and check the section below that is applicable to you.

_____Patient with Insurance

You are responsible for deductibles, co-pays, non-covered services, coinsurance and items considered "not medically necessary" by your insurance company. Please pay co-payments and coinsurance amounts as services are rendered. The remaining balance should be taken care of within one month of statement from Cumming Pediatric Group. If you or your insurance carrier makes payments exceeding your balance, reimbursement will be remitted. If payment cannot be made at each visit, notify the front desk staff to make other arrangements.

The signature below authorizes payment of my insurance benefits to Cumming Pediatric Group.

Insurance Co.______________Policy#_________________Group#_____________

_____Patient without Insurance (Private Pay/Self Pay)

Please make payment for your care at each patient visit. Self-pay patients must pay in full at time of service. A discount is allowed for payment in cash, check or credit card at time of service.

I have read and agree to the payment procedure and assignment paragraph stated above that applies to me.

___________________________ ____________________

Responsible Party Signature Date