Frederick Pediatric Associates

Assignment of Benefits/ Financial Agreement

I certify that the registration information I provided is true and accurate. I authorize payment of health insurance benefits directly to Frederick Pediatric Associates (FPA) customary charges for service rendered. Payment is due upon receipt of services. I am responsible for all fees and charges deemed my responsibility according to FPA and my health plan. If I do not provide a VALID insurance card before services are rendered, I will be held financially responsible for all services. I agree that I will pay any outstanding amounts in accordance with FPA's rates and terms. Should the account be referred to an outside agency for collection, I will pay reasonable fees and collection expenses. It is my responsibility to determine which physician offices participate with my Insurance plan. It is also my responsibility to verify with my insurance company, which services are covered and which services require prior authorization. Any errors therein will result in denial of payment by insurance and is my responsibility for the fees. It is FPA's policy that prescription refill requests are processed only with proper follow up visits and during business hours.

Patient Name: _____ Date of Birth _____

Person responsible for Financial Agreement and terms _____ Date _____

Parent/Guardian if patient is under 18: _____ Date _____

Acknowledgement of Receipt of Privacy Notice

I Patient (or parent/guardian) of Frederick Pediatric Associates, have been given a copy of the Privacy policy. I understand my rights according to this policy and that HIPPA law grants Frederick Pediatric Associates to authorization to use and disclose my medical records for treatment/care and payment operations.

_____ _____

Signature of Patient or Parent Guardian Date

Communication Authorization

Frederick Pediatric Associates may contact me at home/ work or at my home address regarding my diagnosis, results, treatment and care, or payment.

Yes ____ No ____ you may call my cell phone and leave detailed message. # _____
Yes ____ No ____ you may call my cell phone and leave number to call back.

Yes ____ No ____ please use home phone and leave detailed message. #_____
Yes ____ No ____ use home phone and leave number to call back.

Please use email to contact me with detailed Medical information: _____
Email

I understand that I may authorize Frederick Pediatric Associates providers to share medical/billing information about my care/child's care to the following. For a period of one year unless cancelled in writing earlier. Date: _____

_____ _____
Name/ Relationship Phone

_____ _____
Name/ Relationship Phone

_____ _____
Name/ Relationship Phone