PATIENT NAME:_____ **DOB:**_____

ACCOUNT:_____

RESPONSIBLE PARTY STATEMENT:

DEFINITION: --Responsible Party for a child is assumed to be BOTH the legal mother and father of the child presented as a patient unless 'Special Circumstances' are noted below. We cannot bill any other party but the ones who authorize and/or present the child for care on the date of service.

--Responsible Party authorizes Raleigh Pediatric Associates, P.A. to furnish information to insurance carriers concerning patient's illness and treatments.

RESPONSIBILITIES:

1 --**ALL CHARGES** are due at the time that services are rendered unless patient is a member of an insurance plan with which Raleigh Pediatric Associates participates. Raleigh Pediatric Associates only allows contractual adjustments for plans with which our physicians currently have a contract.

--If patient is covered by a plan with which Raleigh Pediatric Associates participates the following will apply:

2 **--COPAYS** are due at the time of service unless the copay is a percentage of allowable charges. In this case, copay will be due immediately after insurance has processed claim with a dollar amount as copay.

3--**ALL CHARGES** deemed patient responsibility after insurance has processed the claim are due **immediately.** This includes copays, deductibles, coinsurance and non-covered services.

4--Responsible Party(ies) are financially responsible for all charges **whether or not covered by insurance.**

5--A valid patient's insurance card must be presented at each and every visit.

6--Raleigh Pediatrics Associates must be notified immediately of coverage changes. Failure to provide us with timely insurance information or change in coverage could result in the responsible party being held liable for the total charges.

7--Any services filed with your insurance that are not responded to any time after 90 days from the date of service may be transferred to patient balance and will become the responsibility of the family.

Kfm 4/2014

RESPONSIBLE PARTY STATEMENT: continued

RIGHTS:

1-- Raleigh Pediatric Associates will file claims promptly for patients who participate with contracted insurance plans.

2--A copy of charge/payment history for account as requested.

3--A copy of this statement may be given upon request to the person(s) who have signed or who have been authorized by the Responsible Party to receive a copy.

4--This statement will be valid unless rescinded in writing by one at a later date.

_____(Your Initials) I have received a copy of Raleigh Pediatric Associates Financial Policy which further outlines my rights and responsibilities.

PLEASE DO NOT SIGN THIS STATEMENT IF YOU ARE NOT THE LEGAL GUARDIAN OF THE PATIENT. NOTIFY THE FRONT STAFF AND THEY WILL PROVIDE YOU WITH A **SPECIAL CIRCUMSTANCES** SECTION :

By my signature I understand and agree to the conditions outlined in this statement and those in the Financial Policy.

MOTHER/GUARDIAN:	FATHER/GUARDIAN:
_____	_____
Printed Name	Printed Name
_____	_____
Signature	Signature
_____	_____
Date	Date

**Staff Initials: _____