

Raybon Pediatrics

700 Zeagler Dr., Ste 7

Ph: 386-385-8137/ Fax: 386-487-2113

Patient Name (s) & DOB _____

Patient's Financial Responsibility Disclosure

As a courtesy, **Raybon Pediatrics** has agreed to file a claim for services rendered with my insurance carrier. I am responsible and expected to pay **Raybon Pediatrics** for the following:

1. Any co-payment as set by my insurance carrier.
2. Any unsatisfied deductible or termination of coverage.
3. Any amount my insurance carrier deems my responsibility.
4. Any amount considered non-covered by my insurance carrier.
5. Any charges for extensive forms preparation or completion.

While my insurance card may state that I am covered at a 100%; there may be additional charges I may incur from my visit today.

I understand that payment is required at the time when services are rendered unless other arrangements have been made in advance. **Raybon Pediatrics** accepts cash, personal checks, VISA, MasterCard. There is a service charge for returned checks.

Failure to resolve any past due accounts including any returned checks will result in dismissal from our practice. To avoid dismissal, Payment plans can be made upon request.

I understand that I will be responsible for a "No Show" fee up to \$25.00 if incurred for not giving (twenty-four) hours' notice of cancellation of any appointment I am unable to keep. This fee will be directly billed to me and not my insurance company for payment.

I HAVE READ THE ABOVE INFORMATION AND AGREE TO BE FINANCIALLY RESPONSIBLE FOR SERVICES RENDERED BY RAYBON PEDIATRICS.

Patient/Parent/Guardian Signature

Date

As Parent/Guardian of the above referenced individual. t will continue to be responsible for all cost incurred for services up to the age of 21.

Parent/Guardian Signature

Date