

# Billing Guarantor Acknowledgement (18 years and older/Foster)



Pediatric Health Care Alliance, P.A.

Your Child's Medical Home™

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Insurance Plan Name: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_ Policy Holder Date of Birth: \_\_\_\_\_ Sex:  M  F

Relationship to Patient:  Parent  Legal Guardian  Foster Parent  Self  Other: \_\_\_\_\_

**\*\*\* PLEASE NOTE: The insurance policy holder is not automatically the Billing Guarantor.**

*The parent/guardian who is present for office visits is the Billing Guarantor - see below for details.*

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## NOTICE OF FINANCIAL RESPONSIBILITY

### BILLING GUARANTOR

**I understand that payment for all medical care is due at the time of service. The parent and/or legal guardian who signs this form is responsible for any and all co-pays, deductibles, co-insurance, and/or unpaid balances not covered by insurance, regardless of marital status. I understand that I am responsible for any costs incurred in the collection of a patient's account in case of default, including reasonable attorney fees and court costs.**

I hereby grant permission to Pediatric Health Care Alliance, P.A. to release any pertinent information to my insurance company upon request, and I also authorize payment directly to Pediatric Health Care Alliance, P.A. A photocopy of this authorization shall be considered as effective and valid as the original.

### NON-COVERED SERVICES

I am aware that some services performed by Pediatric Health Care Alliance, PA may be considered "non-covered" by my insurance carrier or Medicaid, therefore I will become fully responsible for payment of these services.

## NOTICE OF PRIVACY PRACTICES

I have reviewed this office's Notice of Privacy Practices, which explains how protected health information will be used and disclosed. I understand that Pediatric Health Care Alliance, PA has the right to change its Notice of Privacy Practices that will be effective for health information the practice already has about my child[ren], as well as any they receive in the future. PHCA will post a current copy of the Notice. I understand I may receive a copy of the current Notice upon request.

## BILLING GUARANTOR SIGNATURE/CONTACT INFORMATION

I have read all of the above and understand/agree to all provisions therein regarding financial responsibility, permission for treatment, and Notice of Privacy Practices.

Billing Guarantor Name (print): \_\_\_\_\_ Date of Birth (mm/dd/yyyy): \_\_\_\_\_ Sex:  F  M

Billing Guarantor Signature: \_\_\_\_\_ Today's Date mm/dd/yyyy): \_\_\_\_\_

Relationship to Patient:  Parent  Legal Guardian  Foster Parent  Self  Other: \_\_\_\_\_