Pediatric Health Care Alliance, P.A.
Your Child's Medical Home™

Billing Guarantor Acknowledgement (18 years and older/Foster)

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: _____

Important Information
Please note that if your parent still maintain healthcare coverage for you, they may have access to billed procedures, including but not limited to office visits, lab tests (including pregnancy, HIV, and tests for sexually transmitted diseases) or other procedures.

NOTICE OF FINANCIAL RESPONSIBILITY

BILLING GUARANTOR

I understand that payment for all medical care is due at the time of service. The patient, 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 me/ my child (if parent remains guarantor), 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:_____