Pediatric Gastroenterology Associates, Inc.
FINANCIAL & CONSENT FORM

Patient's Name _____ **Date of Birth** _____/ _____/ _____

Name of Responsible Party _____ **Date of Birth** _____/ _____/ _____

CONSENT TO TREAT

As a responsible party for the above named patient, I authorize Pediatric Gastroenterology Associates, Inc. to render necessary treatment in my absence. I authorize the release of any personal, demographic or medical information required to provide continuing and/or consultative medical care.

_____

SIGNATURE OF CUSTODIAL RESPONSIBLE PARTY **DATE**

NOTICE OF FINANCIAL RESPONSIBILITY

As a responsible party for the above named patient, I understand that all charges incurred for all services are my responsibility. It is my responsibility to make payment arrangements BEFORE EACH office visit. Payment is expected at the time of service. **The Practice does Not bill for deductibles, coinsurance or copays**. Assistance can be provided in filing claims with non- contracted insurance carriers. Claims for all contracted plans are handled by the Practice. I accept assignments of benefits to Pediatric Gastroenterology Associates, Inc. and authorize the release of any demographic or medical information required to process claims. While the Practice will make reasonable efforts to identify "NON- COVERED" services PRIOR TO TREATMENT, I accept full responsibility for all costs of collection should my account be turned over to a third party for collection of debt. Cash and local personal, imprinted checks are accepted for payments. The **charge for returned checks** is $28.00 regardless of the reason. Returned checks not redeemed in two weeks will incur an **additional $50.00 charge**.

_____

SIGNATURE OF CUSTODIAL RESPONSIBLE PARTY **DATE**

PAYMENT TERMS: (circle plan) **Self Pay** **Insurance** (Primary/ Secondary) **Medicaid/ GBHC** **PEACHCARE**

Insurance Information: Name of Insured _____ Date of Birth_____/_____/_____

Carrier/ Plan _____Employer _____ Group#_____

Insured's SS# _____Insured's ID #_____ Patient's ID #_____

Thanks for choosing our practice and we appreciate your patronage!!

OFFICE USE ONLY: **Coverage details** **Verified By:_____Verification Date:_____/_____/_____**

Verification #_____ Service Rep Name_____ Effective Date:____/____/____

Specialty Copay $_____ **Ind. Deductible** $ _____ **How Much Met** $ _____

Co-Insurance due by patient $ _____ or % _____

Referral Needed?
- ❑ Yes
- ❑ No

Who is listed as the PCP? _____

PCP's Telephone number ( ) _____

Authorized Lab Facilities

Facility Name	