Meyer Pediatrics
Guarantor Statement of Financial Responsibility

Å I understand that Meyer Pediatrics isa primary care physician's office (PCP). I understand any deductibles, co-pays, and non-covered services are collected at the time of the office visit. I understand if my insurance is inactive or is unable to be verified, I can expect to pay for the office visit and possibly file my own claim. I understand I am responsible for any service deemed non-covered by my insurance. Further, if my account is sent to collections, any costs collecting past due or delinquent charges will be added to my account. I authorize the release of any medical information to my insurance company for claims processing. This authorization/ agreement is effective until revoked in writing.

Å I understand Meyer Pediatrics "missed appointment" charge of $50.00 for failure to give 24 hours notice to cancel or reschedule a well visit. I understand the need to give at least 24 hours notice for prescription refills and for the completion of health forms. I understand access to Meyer Pediatrics "on call"or "after hours" (24 / 7) coverage. I also understand the policy for nurse callbacks and provider callbacks. I understand the Patient Portal is the preferred method for these requests when possible. I understand five (5) working days notice is required for completion of referral to a specialist's office. I understand it is my responsibility to provide required information to Meyer Pediatrics.

Å I understand Meyer Pediatrics **Ř2Ŝă y2ű ǇŊ2ǾʎŘŜ ʎYYdzyʎÎl·űʎ2yã** to patients insured by Medicaid or Medicaid HMO's, patients will be referred to the local health dept for shots. It is my responsibility to make sure that Meyer Pediatrics is designated as my child's primary care physician (PCP) and my responsibility to make sure my child is assigned to an HMO that Meyer Pediatrics is contracted with. Those are: CMS, Coventry, Molina, Sunshine, and Staywell Health. I must notify Meyer Pediatrics within ten days of any changes to my insurance. I am responsible for any unpaid charges that may occur as a result of these changes.

Å **IĿt!! twĿ±!/¸ th[Ŀ/¸ !/Ybh ² [95D9a9b¢Y** I acknowledge that I have received the Health Information Privacy Policy Notice as required by the HIPAA Act of 1996. I may call Meyer Pediatrics and request to speak to the Privacy Officer regarding my children's or dependents protected health information, privacy concerns, or for an explanation of any issues regarding my rights as detailed in the HIPAA Act. I have received a copy of the entire Notice of Privacy Practice. I understand Meyer Pediatrics may use or disclose my protected health information to others only for treatment, payment, or healthcare operations, unless I give my written permission. I understand that I have the right to inspect, correct, amend, or receive copies of my children's or dependents protected health Information (with certain exceptions).

Å **Please list** caretakers, relatives, day care, school officials, and/or anyone who you give permission to share and/or bring your child to this office for medical treatment. I give permission to release my children or dependents Protected Health Information (PHI) to the following individuals.

Name: ________________________________ **Relationship:** _____________ **Date:** ____________

Name: ________________________________ **Relationship:** _____________ **Date:** ____________

I have read and understand the Policies & Procedures of Meyer Pediatrics. I am financially responsible for this account.

Printed name Guarantor/Parent/Guardian: ____

Signature of Guarantor/Parent/Guardian: ____

Todav's Date: _____________________

Revised 3.2016

Note: If completing form online or digitally, your typed name in the above field will be considered legally binding as a written signature.