Financial Responsibility

As a Parent/Guardian of a patient at Hometown Pediatric Care, you are required to sign a financial responsibility form.

On occasion, your insurance may determine the care you have received is NOT a covered benefit. Please read your insurance handbook and be aware of what your insurance offers for benefits. When in doubt, contact your insurance company directly for clarification. You will be responsible for care not covered by your insurance plan.

- Not a Covered Benefit – is not covered or only partially covered by your insurance plan, also may exclude work injury or auto accident.
- Not Deemed Medically Necessary - not provided as the result of illness or injury.
- Before or After Eligibility – serviced provided during a period your policy is not in effect.

I understand that I am financially responsible for all charges, whether or not paid by insurance. I hereby authorize this office to release all information necessary to obtained payments of benefits. I authorize the use of this signature for all insurance submissions.

Patient Name:______________________________ **Date of Birth:**______________________

Additional Children:

1. ______________________________ Date of Birth: ____________________
2. ______________________________ Date of Birth: ____________________
3. ______________________________ Date of Birth: ____________________
4. ______________________________ Date of Birth: ____________________
5. ______________________________ Date of Birth: ____________________
6. ______________________________ Date of Birth: ____________________

______________________________ ____________________

Signature of Patient/Guardian Date

Hometown Pediatric Care