PATIENT FINANCIAL RESPONSIBILITY FORM

Thank you for choosing Gentle Pediatrics, PLLC. as your healthcare provider.

We are committed to providing you the highest quality healthcare. Please read, initial, and sign this form to acknowledge your understanding of our patient financial policies.

I acknowledge the following:

_____ Gentle Pediatrics will bill my insurance on my behalf. I am required to provide the most current and updated information regarding my insurance every visit.

_____ I am financially responsible for all billed services associated with treatment received from Gentle Pediatrics, including any fees which are not covered by my health insurance.

_____ Failure to satisfy any outstanding balance may result in collection efforts being taken against me, including but not limited to, referral to a collection agency or filing suit.

I have read, understand, and agree to the provisions of the Patient Financial Responsibilities Form.

_____

Patient Name

_____ _____

Signature of Patient/Guardian Date