Patient Financial Responsibility

I hereby authorize Goldstar Pediatrics to apply for benefits on my behalf for covered services rendered by the practice. I also assign my benefits and request that all payments from _________________________________ *(insert insurance company)* be made directly to Goldstar Pediatrics. The foregoing insurance company is the *(circle one)* primary / secondary insurance for me. If the foregoing insurance company is the secondary insurance, the primary insurance company is _________________________________ *(insert insurance)* company. I agree to assume responsibility of full payment as allowed by applicable law, in the event that:

- My insurer or self-funded employer does not pay the claim in a timely and accurate manner; or
- The insurer or payer deems the service to be either not medically necessary or to be an excluded or non-covered service; or
- The payer or insurer denies the claim for lack of timely filing or adherence to utilization or payment policies; or
- A claim is prospectively or retroactively denied due to lack of eligibility for benefits.

I certify that the information I have reported with regard to my coverage is correct. I further authorize Goldstar Pediatrics to release to said insurance company and its agents any information related to any claim.

____ **DATE** _________________________
Signature

Relationship to patient_________________________________

Rev 02/23/2016