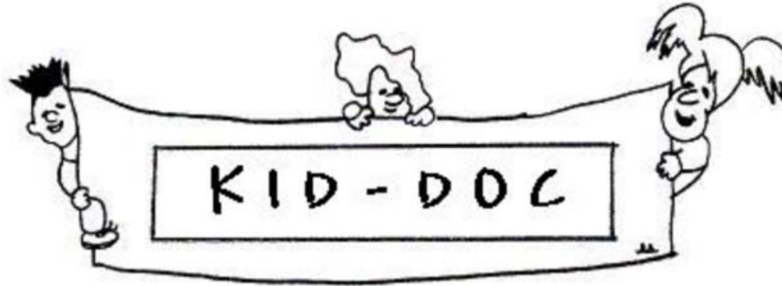

PEDIATRICS

Patients Name: ______________________________

Date of Birth: ________________________________

Release, Assignment, and Financial Responsibilities

1. I understand that I may be charged $25 for appointments not cancelled within 24 hours. Additionally there will be a charge for any forms filled out by the doctor or staff they are as follows: WIC/Daycare/School/ Sports/ Camp Physical $10, FMLA forms $20, Immunization records $5, Medical Records $25 for the first 20 pages then $0.10 cents each additional page.
2. I accept financial responsibility for any test or treatment I agree to or request, regardless of my insurance carrier's responsibility or reimbursement. I acknowledge financial responsibility for services rendered during periods when ineligible for or not covered by my insurance. I acknowledge being informed that my insurance may not cover all services requested. When a denial of a payment is received from my insurance carrier the charge will become my responsibility. My financial responsibility explicitly includes "non-covered" services including but not limited to: all immunizations (including influenza & vaccines for travel), immunization administration charge; after hours, weekend or holiday visit charges; vision screening, hearing screening; treatment for mental health, ADHD, school/behavioral problem (or similar issues), and physical exams or well child visits requested beyond allowance of insurance carrier.
3. I authorized the release of any medical or other information necessary to process a claim with my insurance carrier. I authorize payment of medical benefits to the practice of Dr. Shahzad Sheikh for all services rendered. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

Signature of Parent/ Guardian: ____ Date: ______________

I have read and agree to the Notice of Privacy Practices and am aware that I may request a copy of these policies at any time.

Signature of Parent/ Guardian: ____ Date:_______________