Royal
KIDS
Pediatric Clinic

AUTHORIZATION TO FILE INSURANCE CLAIMS, RELEASE MEDICAL AND BILLING INFORMATION, ASSIGNMENT OF BENEFITS

Patient's Name: _____ Date of Birth: _____

I have read all office and vaccine policies and understand each individual policy.

- I hereby authorize ROYALKIDS CLINIC to file insurance claims for services and supplies rendered to and for my/our child(ren).

- I hereby authorize ROYALKIDS CLINIC to release all information, including my/ our child(ren) medical and billing information, to referring or other consulting physicians and to patient's insurance carriers for the purpose of payment for medical services and further treatment of care by another physician. I further agree that a photocopy of this form shall be as valid as the original.The transmission of all information may be done electronically.

- I hereby authorize ROYALKIDS CLINIC to release my signature and all information necessary to secure the payment of benefits, and assign all benefits and payments from my insurance company directly to ROYALKIDS CLINIC. I authorize that payment of all third-party benefits otherwise payable to me be made directly to ROYALKIDS CLINIC.

- I hereby assign and authorize direct payment to ROYALKIDS CLINIC if any insurance benefits otherwise payable to me or on my behalf for medical services and supplies provided to my dependent child(ren). It is agreed that payment to ROYALKIDS CLINIC, pursuant to this authorization, by an insurance company shall discharge the insurance company of any and all obligations under a policy to the extent of such payment. I understand that I am financially responsible to ROYALKIDS CLINIC for the above-named patient(s). According to this assignment if my insurance company fails to fully compensate ROYALKIDS CLINIC any unpaid balance becomes my sole responsibility.

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- I hereby attest that the insurance information provided to ROYALKIDS CLINIC is accurate, and that I am an eligible member. I understand that I am responsible for knowing my benefits/coverage and acknowledge that tests ordered by my physician may NOT be covered by my insurance company. I agree to pay all amounts not covered or paid by a third- party payer within 45 days from date of service. If I fail to pay within 30 days, from statement date, ROYALKIDS CLINIC has the right to charge my payment card on file, if I have a payment card on file with them. I understand that I will be charged 1% per month finance charge on all accounts over 90 days. Payment is due at the time services are rendered. All charges are my direct responsibility. ROYALKIDS CLINIC cannot render medical services on the assumption that the charges will be paid by my insurance company. If ROYALKIDS CLINIC has problems collecting payment from me, ROYALKIDS CLINIC will also add attorney's fees, collection agency costs and related fees to my bill.

AGREEMENT AS TO CO-PAYMENTS, NON-COVERED OR NON-PAID SERVICES, AND GUARANTEE OF PAYMENT

I understand that ROYALKIDS CLINIC cannot bill for co-payments. Any co-payments or payments for non-covered services are due at the time medical services are provided. I acknowledge that the above information is correct and that I am responsible for the balance on my account for any services not covered or not paid by my insurance company.

I acknowledge that I have received or reviewed a copy of the above office and vaccine policy including Authorization To File Insurance Claims, Release Medical and billing Information, Assignment of Benefits Please Initial _____

Patient/Legal Representative (Print Name):_____
Patient/Legal Representative Signature: _____
Date: _____Time:_____AM/PM
If signed by other than patient, indicate relationship to patient:_____

Witness: _____ Date:_____Time: _____AM/PM