Four Seasons Pediatrics, LLC

Change of Insurance Form

Patient's Name: ______________________________________ DOB:__________________

Other patients this applies to: ______________________________________ DOB:__________________

______________________________________ DOB:__________________

______________________________________ DOB:__________________

(All fields are <u>required</u> for proper processing and identification) (Please have card ready to copy)

Policy Holder
(patient or parent) ____

Policy Holder DOB:___________________ Social Security Number (parent) ______-______-_______(used to bill visits)

Address: ____

Insurance Name_______________________________ Copay / Coinsurance / Deductible ____________

Insurance Policy Number________________________________ Effective Date ___________________

PLEASE READ BELOW CAREFULLY AND SIGN THAT YOU UNDERSTAND THE OFFICE POLICIES

PCP Change: I understand that if my plan requires a <u>Primary Care Provider</u>, I must change this with the insurance before any claims are paid by the insurance. This change must be made effective on or before any dates of service billed by Four Seasons to the insurance. I am responsible for any charges and fees associated with unpaid medical claims for this reason.

Managed Medicaid / Child Health Plus: Failure to name a provider at Four Seasons Pediatrics as my PCP will make any visits viewed as an uncovered service delivered on a <u>Fee For Service</u> basis. As a private pay patient, this and all other uncovered services will be delivered in this manor. I understand that I may obtain medical care at no cost from another provider that participates in my managed care plan. **Four Seasons Pediatrics does not participate in any direct Medicaid or Medicare program.**

COB Information: I understand that if my insurance needs to verify that I have no other medical coverage (Coordination of Benefits information), I am responsible for providing this information to the insurance. I understand that no medical claims will be paid until this information is updated and I will be responsible for payment of unpaid claims.

Deductible: I understand that if I have a deductible with my insurance, I will need to meet that deductible before any payment is made by my insurance. I understand that an office visit can typically range between $80 and $150 dollars after the insurance processes it to my deductible, and I am responsible for this charge. If I have any questions on how my deductible works I will inquire with the insurance directly or a representative from Four Seasons can help explain it to me upon request.

Copayment: I understand that if my insurance requires a copay for any visits, I am responsible for paying this charge AT THE TIME OF THE VISIT. If this is not paid, I will be billed a $5.00 service charge for processing in addition to the copay. This policy applies to all visits even if I have another individual bringing the patient into the office for a visit.

I certify that all above provided information to be true to the best of my knowledge. Four Seasons Pediatrics LLC will use this information to properly bill my insurance company / invoice me for any patient responsibilities and correctly mail me any forms or documents needed for ongoing medical care.

_____________________________________ _________________
Responsible Party (Parent or Patient if over 18) Date

_____________________________________ _________________
Name Printed Relationship to patient