Allegro PEDIATRICS

Financial Responsibility Agreement

I hereby assign payment directly to the provider for services rendered for any benefits available under my insurance, and I am financially responsible for non-covered services rendered. For well child checkup visits, these may include charges for services that are provided in addition to typical routine checkup care.

Currently a vast majority of insurance plans include coverage for well care appointments with no charge to the patient's family. Well child checkups include:

- general assessment of growth and development
- screening for medical, behavioral, and psychological problems
- advice about safety and development
- review of vaccinations and updates as needed
- completion of health forms for school, sports, camps, and other activities
- addressing specific concerns or questions about the child's general well-being

In some instances, a more significant or time-consuming problem will be identified and addressed. If so, the time and effort in addressing that problem may go beyond the scope of what is included in a normal well child check-up. Some examples include:

- a diagnosis of a new problem requiring testing, referral, and/or a new prescription
- an extensive discussion of a new or existing problem
- a procedure such as removal of a bead from the nose or treatment of a wart

These cases may incur additional charges that are outside the scope of your insurance coverage for a well care appointment and may lead to you having some financial responsibility for the visit. If you are having financial difficulties and are unable to pay your bill at Allegro Pediatrics, please contact our billing office at 425-460-5601. We will be happy to discuss the situation with you to see if we can help arrange a workable payment plan.

☐ **I accept** financial responsibility for the patient listed below and acknowledge that I understand the information above.

☐ **I decline** and understand that the patient will not be able to receive medical care at Allegro Pediatrics.

This form must be signed by a parent or guardian if the patient is under the age of 18.

Patient Name _____ Patient Date of Birth _____

Signature of patient or parent/guardian if patient is under 18 _____

Printed Name of Person Signing _____ Date _____ Relationship to Patient _____

Insurance Subscriber's Printed Name _____ Insurance Subscriber's Date of Birth _____ Relationship to Patient _____

This form will be retained in the patient's medical record.