# Patient Financial Responsibility Form/Self-Pay Waiver

Thank you for choosing Noah's Ark Pediatrics for your medical needs, we are committed to providing you the highest quality healthcare. We ask that you read, make the appropriate selection, and sign this form to acknowledge your understanding of our patient financial policies.

**Patient Financial Responsibilities**

The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for treatment and care. **PLEASE CHECK ON BELOW:**

☐ Check here if you agree to the **self-pay rate for services rendered, at time of service.**

☐ Check here if you elect to use available medical insurance for visit coverage. Self-pay rates **will not** apply after date of service.

- We will bill your insurance for you; however, the patient is required to provide the most correct and updated information regarding insurance.
- Patients are responsible for payment of co-pays, co-insurance, deductibles and all other procedures or treatment not covered by their insurance plan.
- Copays are due at the time of service.
- Coinsurance, deductibles, and non-covered items are due after your insurance(s) have responded.
- Patients may incur, and are responsible for payment of additional charges, if applicable.

By my signature below, I hereby authorize assignment of financial benefits directly to Noah's Ark Pediatrics and any associated healthcare entities for services rendered as allowable under standard third-party contracts. I understand that I am financially responsible for charges not covered by this assignment. **I also accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all collection agency fees, (33.33%), attorney fees and/or court costs, if such be necessary.**

Patient Name: _____ Date: _____

Patient/Guardian Signature: _____