MOUNTAIN VIEW PEDIATRICS - PAYMENT POLICY

INSURANCE INFORMATION: *Please give your card(s) to the receptionist so that we may keep a copy on file. All professional services rendered are charged to the patient / guardian. Receipts will be provided for insurance reimbursement.* ***HOWEVER****, the patient /guardian is responsible for all fees regardless of insurance coverage.*

We accept payment by cash, check or credit card (VISA, MASTERCARD, DISCOVER & AMERICAN EXPRESS). We do ask that any co-pay or deductible be paid at time services are rendered. This will help us to keep our costs down. For special cases, please make arrangements with our office manager prior to your appointment.

INSURANCE INFORMATION:

Primary Insurance Name:_____ Name of Insured:_____

Date of Birth of Policy Holder:_____/_____/_____

Group #:_____ ID #:_____

Secondary Insurance Name:_____ Name of Insured:_____

Date of Birth of Policy Holder:_____/_____/_____

Group #:_____ ID #:_____

WE DO FILE & ACCEPT ASSIGNMENT ON THE FOLLOWING PLANS:

Affordable / Health Care Compare
America's Health Plan
Multiplan
Galaxy Health Network
Preferred Health Network
BCE Emergis
USA Managed Care
Medicaid
Blue Cross/Blue Shield of Ga.
United Payors
Community Care Networks
National Hospital Network
Preferred Plan of Ga.
Principal Healthcare (PHCS)
Coventry
Peachcare for Kids
First Health
United Providers
Focus Healthcare Management
Northeast Ga. Health Partners Plus
Multi-Plan
Southcare – PPO
United Healthcare
Tricare

***** PLEASE NOTE *****
This list is updated frequently. Please ask if your plan is not listed.

I hereby authorize ***MOUNTAIN VIEW PEDIATRICS*** to furnish all information to insurance carriers concerning my child(s) illness and treatment and I hereby assign to the physician all payments for medical services rendered to my dependents.

I understand that I am responsible for any amount not covered by insurance.

Date:_____/_____/2014 Responsible Party Signature:_____