NEIL A. PATTERSON, M.D., P.A.

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Financial Responsibility for Adult Children Form

Patient Name:___ DOB:_____

We are pleased to assist you with your adult child's medical needs. If you have medical insurance for your child, please be aware that insurance quotes are an ESTIMATE only. Coverage may be different if your deductible has not been met, annual maximum has been met, or if your coverage table is lower than average.

Co-pays:

I understand that I am responsible to pay all co-payment at the time of service for my adult child, prior to Patient leaving.

Deductible:

If my insurance determines that I have not met the deductible I understand that I will be fully responsible for payment in a timely manner, no more than 30 days after I have been notified by insurance and/or provider.

I acknowledge that I assume full financial responsibility for services rendered to my adult child, if my insurance carrier denies or does not cover the claim for these services. I understand the terms of this form and accept financial responsibility with or without the use of insurance coverage**. I understand that this policy will remain in effect until I provide, Neil A Patterson MDPA, written notification to transfer the financial responsibility to my adult child.**

Responsible Party's Signature: Date:

_____ _____

Name:_____

Address: _____

_____

Phone:_____

PLEASE FAX BACK TO OUR OFFICE AT 407-366-2559