PEDICATRIC PARTNERS OF HAMPTON ROADS, PC

INSURANCE NOTIFICIATION

Thank you for choosing Pediatric Partners as your health care provider. We are committed to your child(ren)'s office visits being successful. Please understand that insurance verification and patient eligibility is considered a part of your office visit. The following is our insurance Verification/ Patient Eligibility Policy which we require to be read and signed in case, for any reason, your insurance coverage is not able to be verified by our office.

By signing this form I completely understand that insurance verification/ eligibility was attempted. If for any reason upon filing my insurance it does not cover all services rendered and charges incurred, I will be held responsible for payment and all non- covered charges.

Child's Name: ________________________________ Date: ___________________

Parent/ Guardian signature: ____