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GUARANTEE OF PAYMENT FORM

This form is to be used by patients claiming insurance coverage eligibility under any of the following circumstances:

1. The patient has no identification card or temporary card or enrollment form.
2. The patient is not listed on our eligibility lists.
3. The patient can not be identified through their insurance member services.
4. The patient can not be determined eligible through our internal verification system.

I understand that Pediatric Health Associates can not confirm my eligibility for medical coverage with _____ at this time. I still wish to receive medical care and will be personally responsible for payment of the charges incurred on this date. Pediatric Health Associates agrees to submit my claims as a courtesy once paid in full. If I am found to be ineligible for medical coverage, my account will be documented accordingly.

I have elected to receive medical care from Pediatric Health Associates even though they are not the primary care physician (PCP) I chose when enrolling with _____. I still wish to receive medical care and will be personally responsible for payment of the charges incurred on this date. I will contact member services to confirm that Pediatric Health Associates is listed as my primary care physician (PCP) prior to any future services.

I will be a participating member with _____ and understand that I have not yet reached my effective date with Pediatric Health Associates. I still wish to receive medical care and will be personally responsible for payment of the charges incurred on this date.

I understand that Pediatric Health Associates will submit a bill to the primary card holder's insurance for payment of charges incurred on this date and any claims that return unpaid I will be personally responsible for.

My signature below acknowledges full financial responsibility for services rendered if the patient is determined as "not eligible" under any of the above provisions. In the event the member receiving medical care is a minor, the undersigned parent/guardian of that minor agrees to be financially liable. Pediatric Health Associates will suspend billing until 9:00am the next business day so the guarantor has the opportunity to provide us with proof of insurance.

(Guarantee of Payment Form Page 2)

DATE OF SERVICE: _____ / _____ / _____
PATIENT'S NAME: _____
BIRTHDATE: _____ / _____ / _____
GUARANTOR'S NAME: _____
SOCIAL SECURITY #: _____
ADDRESS: _____

HOME PHONE #: (_____) _____ - _____
ALTERNATE PHONE #: (_____) _____ - _____
INSURANCE COVERAGE: _____
EMPLOYER: _____
EFFECTIVE DATE: _____

_____/_____/_____
Date

Signature of Patient/Parent/Guardian

Minor Relationship

_____/_____/_____
Date

Signature of Witness