Pediatric Partners of Virginia, LLC

9020 Stony Point Parkway, Suite 165
Richmond, VA 23235

Agreement to Self-Pay/Waiver for Insurance Exclusions

Name of Patient:_____ DOB: _____

It is not promised that your insurance plan will cover all treatment or services provided at today's visit. Pediatric Partners of Virginia, LLC is unable to verify your insurance coverage today, which may result in direct costs to you. You are responsible for verifying your health plan coverage with your insurer. The purpose of this form is to help you make an informed choice about whether or not you would like to receive treatment or services, knowing that you may be responsible for the cost. Please contact our Central Billing Office at 804-330-9100 if you have any questions or would like to know the ESTIMATED cost for the visit today.

☐ **Self-Pay -** I am not covered under a health insurance plan and/or choose not to utilize my health insurance plan. I agree to pay for services in full at the time of the visit. I am aware that there may be services rendered that will be billed separately. If a payment is not made in full at the time of visit, a payment arrangement will need to be made with the Central Billing Office.

☐ **Not Eligible/Out(Max) of Benefits -** I am aware that my insurance coverage is not eligible on this date of service and/or I agree to pay for any services that exceed my plan limits. This means that if the insurance information is not updated or complete, I will be responsible for the full balance of the visit with the provider. I agree to update the insurance and contact the office with any changes.

☐ **A provider at our office is not listed as my child's primary care physician. -**I agree to contact my insurance company and update this information and provide them with today's date of service to ensure billing is correct.

☐ **My child has not been added to my health insurance policy. -** I am aware that I have 30 days from date of birth to make sure my child has been added to my insurance. I will contact my insurance provider and/or my employer to ensure coverage is available for today's visit. I am aware that I may be responsible for any services provided if the child is not added to the policy.

☐ **Other -** _____
_____
_____

An insurance claim will attempt to be filed based on the information provided by me today. I understand and accept that I am financially responsible, as indicated above, for services rendered at Pediatric Partners of Virginia, LLC.

Date: _____ Signature: _____

Relationship to Patient: _____