

PEDIATRICS

Dr. Shahzad A. Sheikh, MD, FAAP
Pediatric and Adolescent Medicine

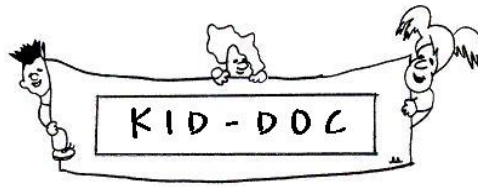
Patient's Name: _____ DOB: _____

Release, Assignment and Financial Responsibilities

1. I accept financial responsibility for treatment or testing I agree to or request, regardless of my insurance carrier's responsibility or reimbursement. I acknowledge financial responsibility for services rendered during periods of ineligibility or uninsured. I acknowledge being informed that my insurance may not cover all services requested. When a denial of a payment is received from my insurance carrier, the charge will become my responsibility. My financial responsibility explicitly includes "non-covered" services including but not limited to: immunizations (including influenza and vaccines for travel), immunization administration charge, after hours/weekend/holiday visit fee, vision/hearing screen, treatment for mental health/ADHD and physical exams or well child visits beyond allowance of insurance carrier.
2. I authorize the release of any medical or other information necessary to process a claim with my insurance carrier. I authorize payment of medical payments to the practice of Dr. Shahzad A. Sheikh for all services rendered. I authorize the use of this signature on all my insurance submissions whether manual or electronic.
3. Additionally, there will be a charge for any forms filled out by the provider or staff not provided at time of visit. They are as follows: WIC, Daycare/School/Sport/Camp Physicals \$10, FMLA paperwork \$20, Immunization record \$5, Medical Record \$25 for the first 20 pages with an additional \$0.10 for each additional page. I understand that I may be charged \$25 for appointments not cancelled within 24 hours.

I have read and agreed to the Notice of Privacy Practices and am aware that I may request a copy of these policies at any time.

Parent's Signature: _____ Date: _____



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Rev 3/2020