Louisville Pediatric Specialists, P.S.C.

AGREEMENT OF FINANCIAL RESPONSIBILITY

ASSIGNMENT OF BENEFITS & RELEASE OF INFORMATION

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PATIENT NAME (Please Print)

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CHART NUMBER

1. **RESPONSIBILITY FOR PAYMENT:**

I understand that I, personally, am financially responsible to Louisville Pediatric Specialists, PSC at 6801 Dixie Hwy., Ste. 127 Louisville, KY 40258 for charges not covered by the assignment of insurance benefits.

2. **ASSIGNMENT OF INSURANCE BENEFITS:**

I hereby assign, transfer, and set over directly to Louisville Pediatric Specialists, P.S.C. sufficient monies and/or benefits for basic and major medical to which I may be entitled for professional and medical care, to cover the costs of the care and treatment rendered to myself or my dependent in said department.

4. **RELEASE OF INFORMATION:**

I hereby authorize and direct Louisville Pediatric Specialists, P.S.C. and any member physician having treated me or my dependent, to release to governmental agencies, insurance carriers, or others who are financially liable for such professional and medical care, all information needed to substantiate claim and payment.

5. COLLECTION FEES:

The undersigned agrees that if this account is not paid when due, and Louisville Pediatric Specialists should retain an attorney or collection agency for collection, the undersigned agrees to pay all costs of collection including court costs, reasonable interest, reasonable attorney's fees and reasonable collection agency fees.

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SIGNATURE OF PATIENT **DATE**

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SIGNATURE OF PARENT OR GUARDIAN **DATE**

Updated 5-6-15
Sherry Baker, RN, CMM, FACMPE
Practice Administrator