Release of Financial Information

Alena Ashenberg MD, Pediatrics
Boston Children's
Primary Care Alliance

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Authorization

I request that payment of authorized insurance benefits be made on my behalf to Alena Ashenberg MD, Pediatrics, LLC for any services provided to my child/my children/myself by their office.

I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related services to my insurance carrier or other medical entity. A copy of this authorization will be sent to my insurance company or other entity, if requested. The original authorization will be kept on file by the office.

I understand that I am financially responsible for any charges not covered by my insurance company, including co-payments that are to be made at the time of service.

I have been informed that as billing is a timely and costly process a $5.00 billing fee will be added to any co-payment that is not paid on the day of service.

It is my responsibility to notify the office of any changes in my health insurance coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the office and/or my health care insurer if the claims or any part of them are denied for payment. I understand that by signing this form I am accepting financial responsibility as explained above.

I also understand that unless 24 hours notice of an appointment's cancellation is given, I will be responsible for a $50.00 fee.

By signing this document, I also acknowledge that I have received a copy of the office's Notice of Privacy Practices. This acknowledgement is required by the Health Insurance Portability and Accountability Act (HIPAA) to ensure that you have been made aware of your privacy rights.

Signature

Patient name: ____

Date of birth: ____

Name: ____

Signature: _________________________ Date: _______________

Relationship to patient: ____________________________________