AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN

PRIVATE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS AND INFORMATION RELEASE

I, the undersigned, authorize payment of medical benefits directly to Prime Pediatrics for any services furnished to me. I understand that I am financially responsible for any amount not covered by my insurance. I also authorize you to release to my insurance company any information concerning healthcare treatment, or supplies provided to me. I permit a copy of this authorization to be used in place of the original.

Signature: _____ Print Name: _____ Date: ____/____/____

MEDICAL SERVICES AUTHORIZATION

I, authorize Prime Pediatrics to give me reasonable and proper medical care by today's standards.

Signature: _____ Print Name: _____ Date: ____/____/____

PAYMENT AGREEMENT

It is the policy of Prime Pediatrics that charges for services rendered by our physician(s) and staff including contractural co pays and deductibles are paid at the time of service unless other formal arrangements have

For your convenience, Prime Pediatrics will file electronic insurance claims; however, it will be your responsibility to provide our office with the necessary information and sign authorization for filing insurance. This information and authorization must be provided to our office at your first visit, accompanied with a copy of your health insurance card(s).

Arrangements for monthly payments may be made with our business staff for any patient account balance. A minimum is required each month to keep your account(s) active. You are responsible for making the monthly payment by the 5th working day of each month regardless is a statement has been sent to you or not. A patient's account that becomes delinquent (monthly payment has not been made within 30 days of the last payment) will be processed in our collections department, and the complete balance will be due immediately. In addition to the complete account balance, you will also be responsible for all attorney fees, court costs, and any collection fee(s) that are incurred.

I agree to the above financial agreement for any services provided to me by Prime Pediatrics.

Signature: Print Name: Date: ____/____/____

Prime Pediatrics, P.C.

Pediatrics and Adolescent Medicine
Ayman Rifai MD FAAP
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Payment for services is due in full at the time service is provided. In the event your account is delinquent and placed with a collection agency you are responsible for the collection fee of 30% of the account balance as liquidated damages, and if an attorney is hired to collect, after maturity, 15% of unpaid principal and interest owing on said account as attorneys' fees. Please sign below stating you have received and read this statement.

Sign Here_____.

Please list Children names._____

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