PGV PEDIATRICS, P.A.

3417 GASTON AVENUE, SUITE 845

DALLAS, TX 75246

PHONE: (214)823-2552

FAX: (214)823-2551

DISCLOSURE AGREEMENT

Patient's Name: _____

Reason for Office Visit:
[] New Patient Exam
[] Follow-up Exam

FOR NON-INSURED PATIENTS:
I/my child does not have any form of medical/healthcare insurance including Medicare or any form of Medicaid. _____ (initials)

IF WE ARE CONTRACTED WITH YOUR INSURANCE AND WE ARE FILING WITH YOUR INSURANCE FOR YOUR OFFICE VISITS:

Check appropriate box (es).

[] My insurance plan covers New Patient well exams.
[] My insurance does not cover New Patient well exams.
[] I do not know if my insurance plan covers New Patient well exams.
[] My insurance plan covers Follow-up /sick exams.
[] My insurance does not cover Follow-up /sick exams.
[] I do not know if my insurance plan covers Follow-up /sick exams.

I recognize that I am responsible for providing my insurance information to PGV Pediatrics, P.A. at the time of service. If I do not have this information, I must pay for my visit and will be provided a statement to file with my insurance carrier myself. _____ (initials)

I agree to pay for any and all medical services I receive from the physicians of this practice that my insurance company refuses to pay, for whatever reason. This office will file a claim on my behalf. However, if my insurance company denies payment for any reason (i.e. non-covered services, terminated coverage, my failure to secure an authorization from my insurance company, I will pay for service upon written/verbal notice of their refusal. Failure by your insurance company to pay for a "clean claim" within 45 days of filing is, for the purpose of this agreement, a refusal to pay. _____ (initials)

_____ _____

Signature of Patient or Responsible Party Date