2175 N. Alma School Rd. Ste.C104 Chandler, AZ 85224
(O) 480.222.6770 (F) 480.222.6771

NEWBORN FINANCIAL RESPONSIBILITY FORM

DATE OF OFFICE VISIT: _____

Patient's Name: _____ Patient's D.O.B.: _____

Parent's/Guardian's Name (Responsible Party):

_____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone number: _____

Alternate Phone number: _____

Our office contacted your Insurance Carrier today and they verified that your child _____, is currently not added to your insurance. If the child mentioned above is a newborn and is covered under mother's current insurance, our office will initially bill the parent's current insurance. No fees except for the customary co-pay(if any) will be collected for this Date of Service. However, it is your understanding that if the child is not added to the Responsible Party's insurance by the time period allotted by the insurance company and today's visit is not covered then today's office visit and subsequent visits to our offices will be your responsibility. Also, if the child drops off of the mother's current insurance and no proof of current insurance is effective then the balance of today's visit will be your financial responsibility.

I HAVE READ THE ABOVE AND UNDERSTAND MY FINANCIAL RESPONSIBILITY TO _____(patient's name) AND HEREBY AFFIX MY SIGNATURE AS AN ACKNOWLEDGEMENT OF THIS UNDERSTANDING.

X _____ Date: _____
Guardian/Parent

Received by: _____