Pediatric and Adolescent Medicine
Drs. Behrstock, Carlson, Gunay, Mann, Pelinka and Taylor

ELIGIBILITY GUARANTEE (revised 06.01.2019)

I hereby:

1. **Assign** my insurance benefits to be made directly to my (child's) physician and/or assisting physicians.
2. Agree that if I **change** my child's insurance coverage it is my responsibility to notify the office.
3. Attest that the above insurance information is accurate and that my child is an **eligible** member. I understand that if my child is **not eligible** for health care benefits then I am responsible for all charges.
4. Will be **financially responsible** for all charges that are not covered by my insurance company, for services rendered in the office, or referrals to another physician/facility.
5. Understand that if a **referral** to another physician or facility is necessary, and our insurance requires specific physicians or facilities be utilized, and/or there are specific requirements regarding their notification or authorization, it is **my responsibility** to notify the office so they can make the appropriate choice and verify.
6. Authorize the **release** of all information to other physicians and insurance carriers upon request for the purpose of payment and/or further treatment.
7. Agree that a photocopy of this agreement shall be as **valid** as the original.
8. Agree **payment** is due at the time services are rendered. If there are problems collecting payments, attorney's fees, collection agency costs and any related fees will be my responsibility.
9. Am responsible for **knowing** and **understanding** my (child's) benefits/coverage. I understand that services cannot be rendered on the assumption that charges will be paid by the insurance company and that coverage is an agreement between me and my child's insurance company.
10. Acknowledge that I have read, understand and agree to hereby give **consent** to assess, treat and test my child.

AUTHORIZATION TO CONSENT TO TREATMENT OF MINOR

I have read and understand the above information. I have been informed of my responsibilities and I understand them fully.

This authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of California.

This authorization shall remain effective until 1 January, 2030, unless sooner revoked in writing and delivered to said agent.

PATIENT'S NAME_____ **DATE OF BIRTH** _____

DATE _____ **FATHER** _____

WITNESS _____ **MOTHER** _____

LEGAL GUARDIAN _____