KinderHealth, LLC

Patient Name: _____ Date of Birth: _____

I have received and understood KinderHealth, LLC Financial Policy.

- I agree to assign insurance benefits to KinderHealth, LLC whenever necessary. _____ (initial).
- I agree to pay copayments, coinsurance, deductibles, services not covered by insurance and any outstanding patient balances (if applicable) PRIOR to being seen by a provider. _____ (initial).
- I agree that if it becomes necessary to forward my account to a collection agency because of lack of payment on legitimate patient balances owed to the practice, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for costs of collections. _____ (initial).
- I acknowledge the same responsibility for the siblings of the above mentioned patient. _____ (initial).

Other children seen at this office:

Name:_____ Date of Birth:_____

Name:_____ Date of Birth:_____

Name:_____ Date of Birth:_____

Name:_____ Date of Birth:_____

Signature of responsible parent guarantor/insured and/or authorized representative:
_____(print name) Date: _____

Relationship to patient: _____