Assignment of Insurance Benefits

MY WHOLE CHILD PEDIATRICS

Naveen Mehrotra, MD, PA

I hereby authorize direct payment of surgical/ medical benefits to Dr. Naveen Mehrotra for services rendered by his supervision. I understand that I may be financially responsible for any balance not covered by my insurance. I hereby authorize Dr. Naveen Mehrotra to release any medical or incidental information that is necessary for either medical care or in processing for financial benefits. I verify that the information given by me in applying for payment is correct. I request that payment of authorized benefits be made on my behalf.

There will be a charge of $25 fee added to my account for same day cancellation of an appointment unless prior arrangements have been made with the office. I understand that there shall be a 1.5% charge per month on any outstanding balance. In the event that my account is not paid, I shall be liable for any and all costs of collection, including, but not limited to an additional 35% fee if my account is forwarded to a collection agency for collection. In addition, I further understand that if legal proceedings are necessary to collect the amount due, I will also be responsible for paying an additional attorney's fees of 20% of the balance, plus court costs.

By signing below, I hereby indicate that:

1) I have read this contract
2) I understand the terms of this contract and
3) I agree to the terms of this contract

Patient's Name (Please Print) _____

Parent/ Guardian (Please Print) _____

Signature_____

Date_____