Bard and Didriksen Pediatrics

Release of Information and Release of Benefits

1) As patient's or authorized person's representative, I authorize the release of any medical or other information necessary to process insurance claims. I understand that my failure to provide the correct insurance information in a timely manner can result in me being responsible for the full amount of the bill for services rendered. I understand I will be required to provide my insurance card for copying at every visit.

2) As insured's or authorized representative, I authorize payment of medical benefits to Angela Bard, M.D., Lizbeth Didriksen, M.D., Jennifer Hulsen, M.D., or David Herman, M.D., Jeong Kim-Judd, M.D. as the supplier of services.

3) I also understand that any charges incurred during this time are my responsibility. I will pay all co-pays at the time of visit, as required by my insurance company.

4) I agree to pay any bank fees or legal fees, including court costs that would incur should I fail to pay this debt. I understand that should my check be returned from my bank for insufficient funds or a closed account or any other reason, I will be charged $25.00 in addition to the amount of the check that was written.

5) I understand that should my account become delinquent for amounts the insurance company has determined are my responsibility, I may not be permitted to bring children for routine well visits, sports or camp physicals until obligation is satisfied. This includes all prior co-pays.

6) I authorize you to give my child/dependent reasonable and proper medical care by today's standards.

7) I understand that if I have Illinois Public Aid and another insurance that the law prohibits me from using IPA as a primary insurance. Bard and Didriksen Pediatrics will not take Illinois Public Aid as a secondary insurance.

8) This will remain in effect until further notice.

9) I understand that I must give a 24 hour notice if I need to cancel an appointment or 2 hrs., in the event of emergency. If I do not bring my child for the scheduled appointment, there will be a $25.00 fee accessed to my account.

Signed_____Date:_____

Relationship to Patient:_____