****

**NEWBORN – 1 MONTH INSURANCE WAIVER**

**Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Insurance Type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**WELCOME TO SALISBURY PEDIATRICS!!**  We must have your child’s insurance card or written verification from your insurance company that your child is eligible for benefits by the 1 month physical. If you do not have this available, the visit will need to be paid in full and arrangements must be made with the billing department regarding the previous balance. Once information is received and insurance payment has been made, you may call to request a refund.

**\*\*The following are guidelines and office policies regarding newborn through 1 month visits when insurance CANNOT be verified.**

1. Patients may be entered into our system as self-pay patients until insurance coverage can be verified and the patient’s insurance card is presented. Until you receive an updated insurance card, we will collect any co-pay/deductible listed on your current card.
2. If no insurance is provided at the 1 month visit, then the visit must be paid in full at time of check-in.
3. Most insurance companies have filing time limits. If Salisbury Pediatrics does not receive the necessary information in time to file, the charge will then be the parents’ responsibility.
4. If you insurance plan requires you to choose a Primary Care Physician, please make certain to select one of our doctors. Many insurance companies will not allow you to change your primary care physician retroactively.
5. **It is the parents’ responsibility to provide our office with the insurance information in a timely manner and follow up with the insurance company until eligibility can be verified.**

**Agreement:** I understand and agree with the conditions described in this waiver. I will assume responsibility for all services that my insurance denies based on coverage, eligibility, and / or benefits.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Responsible Party Date