Cornerstone Pediatrics Insurance Policy

I understand that it is my responsibility to know and understand my insurance policy and coverages. This includes, but is not limited to: what providers I may see, where I can go for additional services like lab work and radiology, if referrals are required, what hospitals I can go to and what items are covered, such as well visits, immunizations, and procedures. I understand that I am responsible for all charges insurance does not cover. I also understand that if my insurance fails to process a claim after 90 days (this includes self-funded plans), or if I fail to provide my insurance with the information required of me to add a child to my policy or process a claim (Coordination of Benefits), my credit card will be charged.

I acknowledge that Cornerstone Pediatrics requires a valid credit, debit or HSA card to be kept on file.

_____ _____ _____

Parent Printed name Signature Date

Child Date of Birth Child Date of Birth

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