Pure Pediatrics, PC
萬友兒科診所

Medical and Financial Consent Form

Date: _____

Patient Name: _____

Date of Birth: _____

To make sure you understand our payment policy for medical services, we describe it as below:

1. Copay must be paid on the day of service.

2. It is your responsibility to pay us any balance that is not paid by your insurance company.

3. If the doctor does not accept your insurance. You will need to pay for our service fees that day. (Mastercard, Visa and Cash accepted).

I agree and give my consent to the physician to provide medical care and treatment considered necessary and appropriate in diagnosing or treating my physical and/or mental condition.

I hereby authorize my Insurance Carrier to pay all fees directly to Pure Pediatrics, PC. I understand that it is my responsibility to know the term of my insurance coverage, including but not limited to eligibility for service, copayment and deductible if applicable. I also understand that I am financially responsible for the medical services rendered if they are not covered by my insurance.

Signature of patient: _____

Telephone of patient: _____

Email Address of patient: _____

Home Address: _____

Staff initial ————

Pure Pediatrics, PC
萬友兒科診所

醫療和財務同意書

日期: _____

兒童的名字: _____

兒童的出生日期: _____

為確保您了解我們醫療服務支付的政策，我們將其描述如下：

1. 就診當天要支付**copay**
2. 您有責任向我們支付您的保險公司未支付的餘額。
3. **如果醫生不接受您的保險公司。**您當天將要支付我們所有的費用。（接受萬事達卡、簽證和現金）。

我明白以上所有的醫療服務支付的政策。我同意醫生提供認爲適合和有必要的醫療護理和治療。我在此授權我(小孩) 的保險公司直接向Pure Pediatrics, PC（萬友兒科診所) 支付所有費用。我明白我(小孩)的醫療保險所涵蓋的醫療費用範圍。我也明白如果保險公司拒絕支付，我將承擔所有的費用。

父母或監護人的簽名: _____

父母或監護人的電話: _____

父母或監護人的郵箱: _____

住址地址：_____

Staff initial ———————