FINANCIAL RESPONSIBILITY POLICY

James Wapshare, our Physician for Goshen Pediatrics, is constantly participating with a variety of insurances. This means that we accept several insurances but may not always be an "IN-NETWORK" or "Preferred Provider" for each plan under an insurer. Being such, we cannot verify the type of coverage for each individual patients' policy as to whether your specific policy considers our physician "IN-NETWORK" or "OUT-OF-NETWORK."

Choosing to receive care by Dr. James Wapshare, you are agreeing to the following:

1. **INDIVIDUAL'S FINANCIAL RESPONSIBILITY**
   - I understand that I am financially responsible for my health insurance deductible, coinsurance or non-covered service.
   - Co-payments and balances are due at time of service. Whoever is accompanying a minor child is responsible for these costs or we can take a phone payment prior to the appointment.
   - If my plan requires a referral for this provider, I must obtain it prior to my visit.
   - In the event that my health plan determines a service to be "not payable" or does not pay for services rendered, I will be responsible for the complete charge and agree to pay the costs of all services provided.
   - If I am uninsured or underinsured, I agree to pay for the medical services rendered to me at time of service.
   - You are responsible to contact your plan to check your benefits and coverage with our provider before the visit.
   - If our provider is considered out-of-network at the time of the visit for you/your child you are responsible for any amount the insurance policy does not cover.
   - If you have health insurance through the Marketplace, you must verify that we are assigned as your/your child(ren)s PRIMARY CARE PHYSICIAN(PCP) for each visit, otherwise you will be responsible for any uncovered services rendered.

2. **INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS**
   I hereby authorize and direct payment of my medical benefits to Goshen Pediatrics on my behalf for any services furnished to me by the providers.

3. **AUTHORIZATION TO RELEASE RECORDS**
   I hereby authorize Goshen Pediatrics to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services as well as information required for precertification, authorization or referral to other medical provider.

*Please note: Person signing this form must be the parent and legal guardian of patient's that are minor's (under 18 year of age) or are their legal Power of Attorney. For patient's that are 18 years of age or older, you are the responsible party unless there is a power of attorney responsible for your healthcare services.

By choosing to have care provided by our physician, you are agreeing to this policy.