



Livermore/Pleasanton Pediatrics Group

Infants • Children • Young Adults

NEWBORN-2 MONTH INSURANCE WAIVER

WELCOME TO LIVERMORE/PLEASANTON PEDIATRICS! - Please read our Financial Policy carefully and sign this form. Because you have a new infant, it is unlikely that your insurance company has added your newborn to your policy yet. Even if you have completed the paperwork it generally takes 30-45 days for the information to be processed. If you have not contacted your insurance company, please do so today since many companies have time limits for adding newborns.

The following are guidelines and office policies regarding visits for newborns through 2 months of age when insurance cannot be verified:

- Patients - will be entered into our computer system as self-pay patients until insurance coverage can be verified AND the patient's insurance card is presented. We will collect applicable co-pays until the 2 month visit.
- Unless parent provides written documentation showing the baby is registered with one of our contracted insurance plans and Livermore/Pleasanton Pediatric Group physicians are chosen as primary care physicians (when applicable). All future visits must then be paid in full.
- 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.
- Most insurance companies have filing time limits. If Livermore/Pleasanton Pediatric Group does not receive the necessary information in time to file, all charges will become the parents' responsibility.
- Please make certain to select one of our physicians as your primary care physician

IMPORTANT - We must have your baby's insurance card or written verification from your insurance company that your child is currently eligible for benefits by the 2 month physical. If you do not have this available, the visit will need to be paid in full and suitable payment arrangements must be made with the Billing Department regarding any previous balance. All applicable credit amounts will be refunded to you once contracted insurance information is received and paid dates of service are either confirmed or paid by the insurance.

Patient Name: _____ Date of Birth: _____

Responsible Party Name: _____

Responsible Party Social Security Number: _____

Home Phone: _____ Cell: _____ Work: _____

Insurance Company Name (attach copy of parent card): _____

AGREEMENT: I understand and agree with the conditions described on this waiver. I assume responsibility for all services that my company denies based on coverage, eligibility and/or benefits. Rev. 4/10

Responsible Party Signature

Date