1 2 8 8

FINANCIAL AGREEMENT FOR PROFESSIONAL SERVICES

You acknowledge that your child may receive professional clinical services by physician groups that are either employed by Nicklaus Children's Hospital or perform professional clinical services as independent contractors to Nicklaus Children's Hospital. As per the Patient Family Agreement, you understand that you may receive bills for clinical services rendered by these physician groups which are in addition to and separate from the bill you will receive from Nicklaus Children's Hospital. Nicklaus Children's Hospital will bill only for the technical components, equipment, medications and supplies used. The physician groups will bill for the professional component, including clinical services rendered on behalf of the patient and, in the case of pathology services, professional oversight of the laboratory. If you have questions about any of the charges, please contact the billing physician group. You may receive bills from the following physician groups:

Adolescent Medicine	Dental	Immunology	Otolaryngology (ENT)	Psychiatry
Allergy/Asthma/Immunology	Dermatology	Infectious Disease	Pathology	Pulmonology
Anesthesiology	Emergency Medicine/Urgent Care	Neonatology	Pediatric Care Center	Radiology
Behavioral Medicine	Endocrinology & Diabetes	Nephrology	Pediatric Critical Care Medicine	Rheumatology
Cardiology	ENT	Neurology	Pediatric Medicine	Urology
Cardiovascular Surgery	Gastroenterology	Neurosurgery	Pediatric Surgery	
Clinical Genetics	Hematology & Oncology	Ophthalmology	Plastic Surgery	
Clinical Research	Hospitalists	Orthopedics	Preventative Medicine	

AGREEMENT

You agree to be responsible for payment to any and all physician groups that render services to your child. As a courtesy to you as the Responsible Party, the physician groups may bill the patient's insurance company or other third party payer for the services provided to the patient. The physician groups' efforts to bill the insurance company or payer and the physician groups' agreement to accept payment from the insurance company or payer on the patient's account will not relieve you of your obligation to make payment to them in full. The amount the insurance company or payer pays the physician group may be less than the full charges (and the amount you then owe them). The physician groups will credit all payments to the patient's account and bill you for the balance, unless the physician group has contracted with the insurance company or payer to accept the amount paid by them as payment in full. If the physician group does not receive payment in full from the patient's insurance company or payer, and the patient is not a member of a health maintenance organization, they may bill you and expect payment in full within thirty (30) days. Interest at the rate of 1.5% per month (18% simple interest per year) shall be assessed on all outstanding balances thereafter or the maximum rate of interest allowable at the time of assessment. All deductibles, co-payments and non-covered charges under the patient's insurance plan are your responsibility. The physician groups are prohibited by law from waiving deductibles, co-payments, and non-covered charges.

Payment for services rendered is the obligation of the Responsible Party signing this agreement. We reserve the right to send unpaid balances to collection. The Responsible Party shall be responsible for payment of all costs associated with the collection of any unpaid balance including interest and reasonable attorney's fees.

ASSIGNMENT OF INSURANCE BENEFITS

You hereby authorize payment to be made directly to the physician groups and assign to them all insurance benefits that may be due and payable with respect to the services rendered. You hereby authorize the physician group and any other holder of medical or other information about the patient to release to the insurance company or payer, the Social Security Administration, the Centers for Medicare and Medicaid Services, and their intermediaries and carriers, any information needed for any claim with respect to the services rendered. Where Medicare and Medicaid benefits are applicable, you certify that the information given in applying for payment under Title XVIII or XIX of the Social Security Act is complete and correct. You authorize the physician groups to use this Agreement as evidence of your consent to bill and receive payment for the services rendered. You further acknowledge that this assignment of benefits does not in any way relieve you of your liability to make payment to the physician group, and that you will remain financially responsible to the physician group until all charges are paid in full.

If benefits are not assignable or if an insurance carrier renders payment directly to the insured or the Responsible Party, Responsible Party agrees to forward to Nicklaus Children's Hospital all health insurance and other third-party payments received by the patient or by Responsible Party for services rendered to the patient immediately upon receipt. Failure to forward health insurance or other third party payments may result in waiving any negotiated discounts Responsible Party may otherwise enjoy.

I have read and understand each of the above paragraphs and I acknowledge and accept these terms and conditions.
I understand that the services being provided are being furnished by a department of Nicklaus Children's Hospital.

Signature of Responsible Party _____ Date _____

Signature of Witness _____ Date _____

Responsible Party

Name: _____ Relationship to Patient: _____

Address: _____ Telephone Number: _____

Please indicate legal authority of Responsible Party:

- ☐ Parent/Guardian of a minor
- ☐ Healthcare Surrogate (attach document)
- ☐ Self
- ☐ Power of Attorney (attach document)
- ☐ Court Appointed Guardian (attach document)

FINANCIAL AGREEMENT FOR PROFESSIONAL SERVICES

NICKLAUS CHILDREN'S HOSPITAL
MIAMI, FL 33155
FORM # 798.073.1288 (NURS1288)
VERSION 1