600 Waukegan Rd, Unit 132
Northbrook, IL 60062
847-784-8733
kidnectivity.org

Financial Responsibility Form

Patient Name: _____ Date of Birth_____/_____/_____
Guarantor for this account: _____
Relationship to patient: _____
Home Phone _____Cell Phone_____
Work Phone _____ Email _____
Address_____
City_____State_____Zip_____

Kidnectivity will verify the patient's insurance benefits if we are billing insurance, but this verification is not a guarantee of payment. We will perform a benefits check for all insurance providers, regardless of whether we are an in-network or out-of-network provider. The guarantor (either the patient or person named) is responsible for payment of any and all balances on the account (copays, coinsurance amounts, visit charges not covered by insurance, and missed appointment charges.)

If after 90 days from date of initial claim filing, we have not received payment from your insurance company, the full payment becomes the responsibility of the guarantor. We will continue to pursue reimbursement from the insurance company and resolve any payments from them with you.

If we are an out-of-network provider with your insurance company or you are not utilizing insurance, we require a credit card on file. We will charge your account balance at the end of the month. You will be notified via email in advance of any charges made to your credit card.

If you have any questions regarding your insurance coverage, please contact the insurance company for clarification. If you have any other questions regarding billing and insurance specific to Kidnectivity, please contact our office at 847-784-8733.

As guarantor for this account, I acknowledge my responsibility for payment on this account.

_____ _____
Guarantor Signature **Date**

_____
Witness

Last updated 7/5/16