Lawrenceville Pediatrics, P.C.

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ADVANCE BENEFICIARY NOTICE

Date: _____ Patient: _____

Insurance Company: _____ Policy Holder: _____

You are receiveing this notice because your insurance company may not pay for all of the services your child may receive during your visit at our office.

What you need to do now:

- Read this notice, so you can make informed decisions about your care.
- Ask questions (of our office and your insurance company.
- Decide if you still want your child to receive this services.

Supplies and/or Services:	Reason Insurance May Not Pay:
Newborn visit.	Newborn is not fully added to insurance policy yet. *You have 30 days to add your newborn to your insurance policy or get them on their own insurance.

☐ YES, I want my child to still receive these services. If my insurance company denies payment, I understand I am completely responsible for payment of any balances in full. I understand that I can appeal this decision for nonpayment with my insurance carrier.

☐ NO, I have decided not to receive these services today.

By checking "YES" and signing this notice, you agree to take financial responsibility for the cost of supplies and/or services listed above should your insurance company deny coverage for the listed items.

_____ _____

Parent/Guardian Signature Date