Insurance Waiver

Commonwealth Pediatrics
Boston Children's
Primary Care Alliance

commonwealthpediatrics.com
781-451-0072

Patient name(s):

1. _____

2. _____

3. _____

Date of service: _____

I understand it is my responsibility to be familiar with my obligations to and the policies of my insurance plan. I understand I may discuss these issues in private with our office manager. Should any services not be covered for my child's care, I understand I am responsible for full payment. This may include, but is not limited to:

- Not informing my insurance company of a change in primary care provider
- Non-covered services or procedures
- Invalid or expired coverage
- Failure to inform the office of any insurance change(s)
- Failure to produce a current insurance card for the patient
- Seeking care through this office for a plan with which we do not contract
- Immunizations not covered by my insurance company

If you have commercial insurance that we do not accept, or your commercial insurance is inactive, you may be considered a self-pay patient, and full payment is expected at the time of service. If you have a Medicaid insurance plan, please be advised that **we only accept Tufts Health Together with Boston Children's ACO** as the primary insurance plan. You must be listed with this plan AND have one of our providers listed as your primary care provider (PCP) in order to be seen. If this insurance is listed incorrectly, you will be asked to call the insurance plan to correct the information and obtain a reference number before you will be seen. If your Medicaid insurance plan is active, we may not list you as a self-pay patient.

I understand making the necessary changes with my insurance plan is my responsibility, and that I may reschedule my appointment to a date when the plan has been corrected if I so choose. If I do reschedule, and my child is due for vaccines covered by the Vaccines for Children program, I understand they may receive those today if I choose.

Parent/guardian name:

_____

Parent/guardian signature:

_____