

Nuga Pediatrics Lenawee

Billing Policy

I understand that I am responsible for the payment of all balances on my account; these may include Co-pays, deductibles or non covered services. Charges for services (par and non –par) rendered by Dr. Adenuga/Nuga Pediatrics regardless of insurance coverage are my responsibility. I understand that Dr. Adenuga/Nuga Pediatrics will always attempt to bill the insurance carrier I have on file.

Signature on File

I hereby authorize Nuga Pediatrics to submit to my insurance plan charges for all services rendered by Dr. Adenuga and to furnish complete information (including medical records were necessary) to my plan. I understand that in signing this form Nuga Pediatrics will not release any of my child's information that the Law expressly protects to anyone, including those processing the claim. In order for my child's protected records to be released, I will need to sign a separate content form. I further authorize and direct my insurance carrier to Issue payment checks directly to Dr. Adenuga/Nuga Pediatrics all services rendered to my child.

Authorization Signature

I have read this form or had it read to me.
I understand the contents fully and I hereby append my signature herein below as an affirmation of my consent.

Patient's Name

Patient's Date of Birth

Print Parent/Guardian Party's Name

Relationship to Patient

Signature Parent/Guardian Party

Signature on File date