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Jacinta White Topps, M.D.
Claudia E. Sussdorf, M.D.
Sita S. Canady, M.D.

NON-PARTICIPATING/SELF-PAY NON-EMERGENT SERVICES

Patient Name: ____

Provider Name: ____

Location of Services: ____

Insurance Plan: ______________________________ Policy #/ID: ___________________

Non-Participating/Uninsured Waiver:

If applicable, I have been verbally informed by Fall Hill Pediatrics on this day, ______________ (mm/dd/yyy), that they do not participate with my insurance and my medical claims will be processed as "Out of Network"/uninsured.

If applicable, as a courtesy, Fall Hill Pediatrics will submit the claims to your insurance carrier for processing. Since there is not participating agreement with your plan, you will be responsible for the full payment of these charges. The amount received from your plan is NOT acceptable as payment in full. For any questions regarding reimbursement, please contact your insurance carrier directly. If you are uninsured and you have questions, you may contact our billing company at (877)589-7851.

The undersigned accepts full responsibility for all items or services provided, and have agreed to complete the appointment on ______________ (mm/dd/yyy).

Parent/Guardian Signature: __________________________________ Date: __________________