AHMAD & RANA PEDIATRICS LTD.

Shafique Ahmad MD.
Jamil Rana MD.
Misha Martinez MD.
Jarod Skouby MD.
Shahnaz Ahmad MD.
Jennifer Loethen MD.

Release of Information & Benefits

1. As patient's or authorized person's representative, I authorize the release of any medical or other information necessary to process insurance claims. I understand that my failure to provide the correct insurance information in a timely manner can result in me being responsible for the full amount of the bill for services rendered.
2. I understand I will be required to provide my insurance card for copying at every visit.
3. As insured's or authorized representative, I authorize payment of medical benefits to Shafique Ahmad, MD., Jamil Rana MD., Misha Martinez MD., Shahnaz Ahmad MD., Jennifer Loethen MD., Jarod Skouby MD., as the supplier of service.
4. I also understand that any charges incurred during this time are my responsibility. I will pay all co pays at the time of visit, as required by my insurance company. Any copay not paid at the time of service will incur an additional fee.
5. I agree to pay any bank fees or legal fees, including court cost that would incur should I fail to pay this debt. I understand that should my check be returned from my bank for insufficient funds or a closed account or any other reason, I will be charged $25.00 in addition to the amount the check was written for.
6. I understand that should my account become delinquent for amount the insurance company has determined are my responsibility, I may not be permitted to bring children for routine well visits, sports or camp physicals until obligation is satisfied. This includes all prior co-pays.
7. I understand that if I have Illinois Public Aid and a secondary insurance that the law prohibits me from using IPA as a primary insurance.
8. I understand that I will arrive promptly to my child's appointment, and cancel/reschedule appointments in a timely manner when unable to make them. I understand that if I am 15 minutes late I may be asked to reschedule the appointment and I will not be seen. Missing 3 appointments could result in termination of services and my family may be asked to find another health care provider.
9. As a patient of Ahmad & Rana Pediatrics LTD. I agree to follow the vaccination schedule as set out by this office and the CDC.

Signature Date

Printed Name Relationship to Patient