Hawthorne Pediatrics

330 Lafayette Ave.

Hawthorne, NJ 07506

Patient Responsibility Agreement

Patient Name: _____

Date: _____ / _____ / _____

I, _____, am a member of _____,
(insurance name)

and I have scheduled treatment from Hawthorne Pediatrics.

I understand that the federal letter and an authorized referral number is required prior to scheduling this visit in order to assure that it is a covered benefit. I also understand and agree that is my responsibility to obtain the required referral and / or authorization and I will be responsible for payment of charges and will be billed directly.

Signature of Patient of Guardian: _____

Date: _____ / _____ /_____