

Central Florida Pediatrics Financial Statement & Authorizations

It is the policy of this practice that payment in full is due at the time services are rendered. We are happy to accept your payment by: check, cash, Visa, MasterCard, Discover or American Express. We will submit claims to those insurance companies with which we have a contract (a list is provided below), however it is the sole responsibility of the insured to know the type of insurance, assigned primary care physician and copays or deductibles. All other patients will be given receipts that will be sufficient to submit to an insurance company for reimbursement. **All copays, deductibles, and patient percentages are due at the time services are rendered.** Any balances that are over **90 days** past due will be turned over to a collection agency unless previous arrangements have been made. Initial _____

Your Signature Will Serve for All of the Following

Consent: I hereby give consent to Central Florida Pediatrics to provide necessary treatments discussed. I have received a copy of the Privacy Policy of Central Florida Pediatrics and authorize use/disclosure of information to coordinate and/or manage my child(ren)'s healthcare and any related services, receive payment for services and perform general healthcare operations. Initial _____

Medical Release: I authorize any holder of medical or other documentation about my child(ren) to release to Central Florida Pediatrics, independent laboratories and insurance carriers any information needed for claims processing & payments. I permit a copy of this authorization to be used in place of the original. Initial _____

Insurance Authorization: I authorize payment of medical benefits to the attending physician for services. Initial _____

Financial Responsibility: I understand that I am ultimately responsible for all charges incurred by my child(ren). It is my responsibility to provide the office with all necessary information to file insurance claims, and to notify the office of changes in coverage prior to any visits. I understand that it is my responsibility to know my insurance coverage and benefits, including contracted laboratories/hospitals where my child(ren) may receive care. **I will be responsible for any charges not covered by my insurance policy, including a \$15.00 fee per call placed after hours.** I understand the above financial statement of timely payment. I understand that any returned checks may be re-deposited electronically, including all fees assessed. Initial _____

Signature: _____
Parent/Legal Guardian

Date: _____

Print Name: _____ Child(ren): _____

WE GLADLY BILL TO THE FOLLOWING INSURANCE COMPANIES*:

Accountable Health Plans
Aetna USHealthcare
All Florida PPO
Avmed
Beech Street
Benesight
Blue Cross & Blue Shield
CCN PPO
CFMA
Cigna

Definity Health
Endeavor
Evolutions Healthcare
First Health
Fiserv
Florida Health Care Triple Options
FMH Benefits
Fortis
Golden Rule
Great West

Health Choice
Humana
One Health Plan
PPONext
Preferred Health Network
Private Healthcare Systems
Southcare / Coventry Healthcare
United Healthcare
Unicare
Volusia Health Network

*Contracts subject to change without prior notice.