Central Florida Pediatrics

2020 Financial Statement and Authorizations

Financial Responsibility: Payment is due in full at the time services are rendered, regardless of divorce decrees or if the party accompanying the patient is not the parent/guardian. **If payment is not made in full at the time of service, a $25 nonpayment fee will be assessed.** If a check is returned from the bank, a $25 returned check fee will be assessed.

Insurance Plans: We will submit claims to primary insurance companies with which we are participating providers. **We do not bill secondary insurance companies**. It is the parent's responsibility to pay any balances not paid by their primary insurance and file a claim directly with any secondary insurance. We cannot send claims to any insurance company we are not contracted with, including Medicaid and auto insurance companies. Parents/guardians are ultimately responsible for all charges incurred if an insurance company does not pay within 60 days or if the services are not covered on the patient's insurance plan. Our office will attempt to verify the medical coverage as a courtesy; however this is not a guarantee of coverage or payment by the insurance company. It is the sole responsibility of the parent/guardian to understand the patient's coverage, including maximum benefits, copays, or deductibles, as well as provide our practice with current insurance information.

Account Balances: Our office sends statements once a month for any unpaid balances to the address on file. It is the parent/guarantor's responsibility to update contact information, including addresses and/or phone numbers. Any balance that becomes past due will be considered for referral to a collection agency at which point our practice will no longer provide medical care to the patient and siblings.

Appointments: Any appointment not cancelled 24 hours prior to the appointment time will be considered a missed appointment and a $25 fee may be assessed. Two or more missed appointments on an account (which consists of all patients in the family), may result in dismissal from our practice. This fee is not covered by insurance plans.

Continuity of Care: All children should be evaluated by their primary care physician, as part of a routine physical, according to current AAP guidelines. We require all of our patients to follow these guidelines so that we can monitor their development and growth. Failure to do so may result in dismissal from our practice.

After Hours Phone Calls: Our office provides a triage service for any concerns that parents/guardians may have after hours. However, there may be a $20 fee per call for use of this service to offset our cost. This fee is not covered by insurance plans. Many insurance companies offer a 24-hour nurse hotline for concerns after our normal office hours.

Saturday Appointments: There will be an additional $25 fee assessed for weekend or evening appointments.

Prescription Refills and Forms: Please contact our office during normal business hours for any prescription refill requests. Allow 24-48 hours for these requests to be completed. Forms will be completed within 48-72 hours of the request, including physical and immunization forms. Medical records will be released within 10 working days after we receive the authorized request.

Consent: I hereby give consent to Central Florida Pediatrics to provide the necessary treatments for my child(ren)'s medical care. I have received a copy of the Privacy Policy. I authorize Central Florida Pediatrics to use or disclose pertinent information to coordinate my child(ren)'s medical care. I authorize payment for covered healthcare services performed to be paid to Central Florida Pediatrics.

I give my permission for Central Florida Pediatrics to leave phone messages regarding my child(ren)'s medical information, laboratory results, test results, or appointment information. If I choose to restrict Central Florida Pediatrics from leaving messages at the phone number on file, I will notify the practice.

PARENT/LEGAL GUARDIAN ACCEPTANCE OF THESE POLICIES

_____ _____

Signature Date

_____ _____

Print Name Relationship to Child(ren)

Child's Name: _____ Date of Birth: _____

Child's Name: _____ Date of Birth: _____

Child's Name: _____ Date of Birth: _____