

Central Florida Pediatrics

Financial Statement and 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 (see below for a partial list); however it is the sole responsibility of the parent/guardian to know the type of insurance, assigned primary care physician, and copays or deductibles. **If payment is not received at the time of service, a \$10 nonpayment fee will be assessed.** Any balances that are over 90 days past due will be turned over to a collection agency and the children will be dismissed from the practice unless previous payment arrangements have been made.

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

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

Financial Responsibility: I understand that I am ultimately responsible for all charges incurred by my child. 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 well child maximums and contracted laboratories/hospitals where my child may receive care. I will be responsible for any charges not covered by my insurance policy, including a \$15 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. I understand that there is a \$10 fee when payment is not made at the time of service. I understand that this fee is my responsibility and will not be sent to my insurance company.

Appointments: If you need to cancel an appointment, please contact our office at least 24 hours before the appointment. If a patient misses two appointments, a \$25 fee will be assessed that is not reimbursable by insurance companies. If a third appointment is missed, the child and any siblings may be dismissed from the practice.

Parent/Legal Guardian: _____ Date: _____
Signature
Print Name _____ Child(ren): _____

WE GLADLY BILL TO THE FOLLOWING INSURANCE COMPANIES*:

AETNA	Florida Health Care Triple Options	Primary Physician Care
Avmed	FMH Benefits	Private Healthcare Systems
Beech Street	Golden Rule	Southcare
Blue Cross & Blue Shield	Great West	Tricare Standard
Cigna	Health Choice	UMR
Coventry	Mega Life/Mid-West National	United Healthcare
FBMC/FSAI	Humana	Volusia Health Network
First Health/MultiPlan	PPONext	WellCare (HealthEase and Staywell)

*Contracts subject to change without prior notice