PEDIATRICS OF CENTRAL FLORIDA, P.A.

PATIENT INFORMATION

FORM MUST BE FILLED OUT COMPLETELY AND ACCURATELY IN ORDER TO REACH PARENTS WITH RESULTS AND TO PROPERLY BILL YOUR INSURANCE TO AVOID CHARGES BEING PASSED ON TO THE GUARANTOR.

ALLERGIES _____ **(PLEASE PRINT)** PRIMARY LANGUAGE _____

Patient Name: _____
Last First Middle Initial

Patient Address: _____
Number & Street City State Zip Code

Home Phone ( ) _____ Date of Birth: _____ S.S. # _____ Sex: _____

Race: ☐ Caucasian ☐ Black ☐ Hispanic ☐ Asian ☐ Other _____

Name of Pharmacy: _____

Address: _____
Street City State Zip Code

Phone: _____

Mother _____ Soc. Sec. #: _____ Date of Birth: _____

Address: _____ Home Phone ( ) _____
(if different than patient's)
Cell Phone ( ) _____
City State Zip

Employer: _____ Work Phone ( ) _____

Father _____ Soc. Sec. #: _____ Date of Birth: _____

Address: _____ Home Phone ( ) _____
(If different than patient's)
Cell Phone ( ) _____
City State Zip

Employer: _____ Work Phone ( ) _____

Guardian: _____ Soc. Sec. #: _____ Date of Birth: _____
(If applicable)

Address: _____ Home Phone ( ) _____

Cell Phone ( ) _____

Employer: _____ Work Phone ( ) _____

Emergency Contact (other than Mother/Father)

_____ _____
Emergency Contact Name Phone Number

INSURANCE INFORMATION

Name of Insurance Company: _____ Group #: _____

Name of Subscriber: _____ I.D. #: _____

Do you have any additional health insurance for the child? ☐ Yes ☐ No

Treatment Agreement

I authorize Pediatrics of Central Florida, its physicians and support staff to medically treat and/or administer necessary medications and/or immunizations when my child's doctor deems advisable in the diagnosis and/or treatment of my child.

Signature of Responsible Party: X _____ **Date:** _____

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Guarantor Financial Agreement

This statement has been prepared to prevent confusion and uncertainty regarding office financial policies and procedures. Please remember that insurance is a financial arrangement by which patients obtain reimbursement for medical fees and is not a substitute for paying the doctor. There is considerable variation in the extent to which insurance companies cover various medical expenses.

I request that payment of authorized Health Insurance benefits be made on my behalf to Pediatrics of Central Florida, P.A. for any services furnished me by that group. I authorize any holder of medical information about my child/children to release (via facsimile, mail or telephone) to the Heath Care Financing Administration or Health Insurance Company and its agents any information needed to determine these benefits or the benefits payable for related services.

Pediatrics of Central Florida is committed to providing the best treatment for our patients. We must emphasize that as medical care providers, our relationship is with our patient, not with your insurance company. We cannot accept the responsibility of negotiating the claims with insurance companies or other persons. **While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date services are rendered.**

Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract, although we may be a participating provider for that network. That means simply that when payments are received, we will make contractual adjustments as outlined in our participation agreement with that plan or network. It is the patient's responsibility to understand the provisions of their plan. We cannot guarantee payment of all claims. If your insurance pays only a portion of your bill or rejects your claim, any contact or an explanation should be made to you in writing from your insurance company. Reduction or rejection of your claim by your insurance company does not relieve you of your financial obligation.

COPAYS AND DEDUCTIBLES MUST BE PAID AT THE TIME OF EACH VISIT.

Pediatrics of Central Florida gladly accepts Visa, MasterCard, Discover, American Express, Check or Money Orders. POCF prefers debit/credit rather than cash.

PLEASE READ AND SIGN THE FOLLOWING AGREEMENT

I hereby assign insurance benefits, otherwise payable to me, to pay directly to Pediatrics of Central Florida. I understand I am responsible for charges and guarantee payment not covered by my policy. I agree to be solely responsible for all collection fees, attorney fees, interest, and court costs necessary to collect payment on any portion of the delinquent balance.

By signing this agreement, I have been made aware there is a $30 charge for missed appointments. A 24 hour notice MUST be given to prescheduled appointments and 1 hour for same day sick appointments in order to reschedule or cancel. Telephone nursing help is available after-hours through a contracted service. You may reach them through our answering service in the evening. Please note, a $15.00 fee is charged to the patient. A fee of $25 is charged for completing all FMLA forms.

Guarantor's Name (please print): _____

Signature : X _____ Date: _____