Pediatric Neurology Associates

A Division of Florida Pediatric Associates, LLC

Account# _____ *PATIENT INFORMATION*

Patient Name: _____ DOB: ___/___/___ SS#: ___-___-___ Sex: Male ___ Female ___

Address: _____ City: _____ State: _____ Zip: _____ Phone#: (___)_____

Race: ☐ African American/Black ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ White

Ethnicity: ☐Hispanic ☐Non-Hispanic ☐Declined

Other family members treated here: _____

Primary Care Physician: _____ Phone#: (___) ___-___

Pharmacy : _____ Pharmacy Phone: (___) ___-___

Email: _____

Preferred Method of contact: ☐ Mail ☐ Home Phone ☐ Cell Phone

Whom may we thank for referring you: _____

PARENT(S) / LEGAL GUARDIAN INFORMATION

Who has legal Custody of the Patient: ( )Parents ( )Mother Only ( ) Father Only ( ) Foster Parent ( ) Grandparent ( ) HRS/Other

IF NOT BIOLOGICAL/NATURAL PARENTS, COURT DOCUMENTS MUST BE PRESENT AT TIME OF VISIT

Mother/Guardian's name: _____ DOB: ___/___/___ SS#: ___-___-___

Address: ☐Check here if same as above

_____ City: _____ State: _____ Zip: _____

Home #: (___)___-___ Cell#: (___)___-___ Work#: (___)___-___

Occupation: _____ Employer _____ Employer Address _____

Father/Guardian's name: _____ DOB: ___/___/___ SS#: ___-___-___

Address: ☐Check here if same as above

_____ City: _____ State: _____ Zip: _____

Occupation: _____ Employer _____ Employer Address _____

Home #: (___)___-___ Cell#: (___)___-___ Work#: (___)___-___

Preferred Language: _____

EMERGENCY CONTACTS

#1. Name: _____ Relationship: _____ Phone#: (___) ___-___

#2. Name: _____ Relationship: _____ Phone#: (___) ___-___

Jan-14

INSURANCE INFORMATION

Primary Insurance Carrier: _____ Policy#_____ Group#_____

Policyholder's Name: _____ **Date of Birth**_____

Policyholder's SS#:: _____ **Relationship to patient:** _____

Claims Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Eligibility Phone# (_____) _____-_____

Secondary Insurance Carrier: _____ **Policy#**_____ **Group#**_____

Policyholder's Name: _____ **Date of Birth**_____

Policyholder's SS#:: _____ **Relationship to patient:** _____

Claims Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Eligibility Phone# (_____) _____-_____

ASSIGNMENT OF BENEFITS/ACKNOWLEDGMENTS

I request that payment of authorized insurance benefits be made on my behalf to Florida Pediatric Associates, LLC for any medical services provided to me by that organization. I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related equipment or services to the organization, the Health Care Financing Administration, my insurance carrier or other medical entity. A copy of this authorization will be sent to the Health Care Financing Administration, my insurance company or other entity if requested. The original will be kept on file by the organization.

I understand that I am financially responsible to the organization for any charges not covered by health care benefits. It is my responsibility to notify the organization of any changes in my health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the organization and/or my health care insurer if the submitted claims or any part of them are denied for payment.

I understand that by signing this form I am accepting responsibility as explained above for all payment for products received.

By signing this document, I also acknowledge that I have received a copy of the organization's Notice of Privacy Practices. This acknowledgement is required by the Health Insurance Portability and Accountability Act (HIPAA) to ensure that I have been made aware of my privacy rights.

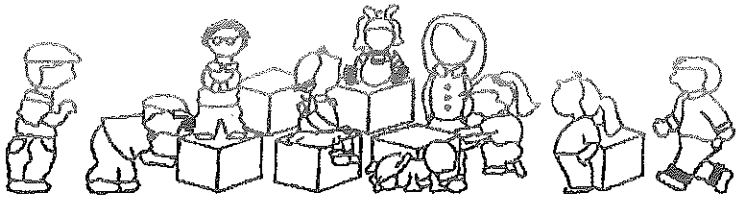
Parent/Guardian Signature_____ **Date**_____

OFFICE POLICY FOR PAYMENT

Payment is expected IN FULL at the time services are rendered by the patient or the person accompanying the minor child for treatment. If our office is a participating provider with your insurance carrier, all non-covered services, co-pays, and or deductibles will be collected at the time of each visit. Arrangements for anything other than full payment at the time of service must be made prior to your appointment. It is the responsibility of the guarantor to understand and accept the guidelines set up within the individual's insurance plan. If you are unable to provide us with complete insurance information at the time of your visit you will be responsible for payment of services IN FULL. I understand that I am financially responsible for any balance not covered by my insurance carrier. I further understand and agree, that if I fail to make timely payments on my account, I will be responsible for any and all reasonable costs of collection, including filing fees as well as reasonable attorney's fee.

I have read and understand the office policy for payment and agree to the terms as stated.

Parent/Guardian Signature_____ **Date**_____



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Permission to Treat

I, _____, authorize Pediatric Neurology Associates and
(Print name of legal guardian)
its personnel to provide medical services such as medical examination and treatment, as they deem best for the child's physical or mental welfare.

_____ _____ _____
(Print child's name) *(Date of birth)* *(Social Security #)*

I authorize the following person/people to bring my child in for treatment and to discuss any necessary treatments, medications and to even authorize any tests or labs that are necessary up to and including admission to the hospital.

Mother's Name:_____

Father's Name:_____

Name:_____ Relationship to patient: _____

Name:_____ Relationship to patient: _____

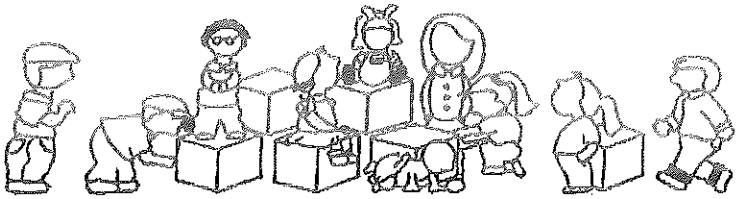
**All of the above will provide identification to be placed in the patients chart.

I agree that unless I give specific instructions otherwise, medical information regarding my child's diagnosis and treatment may be released to biological parents, step parents, referring physicians and other practitioners, and my insurance company.

I have been advised and understand the Notice of Privacy Practices of Pediatric Neurology Associates, P.L.

_____ _____
Signature of legal guardian ***Date***

Relationship to patient: _____



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Financial Policy

Patient Name_____ Date of Birth_____

Due to pending federal regulation ("Red Flag" rules) which will impact medical practices, we have revised our policy with respect to patients carrying balances "receivables" with our office.

Our policy will now reflect that outstanding balances for copayments, coinsurance percentages, deductible amounts and missed appointments must be paid prior to your child's next office visit. If your balance is not paid in full, your appointment will be rescheduled. Most health plans allow you to verify the potential patient portion for a visit in advance of your visit. Review your insurance plan documents to inform yourself of any copayment, coinsurance percentage, or deducible amount which may apply to your visit and be prepared to pay for those in advance.

Health insurance plans and Florida Medicaid do not pay for missed appointment fees of $25.00 Missed appointment fees can easily be avoided by simply keeping your scheduled appointment or cancelling via phone at least 24 hours prior to the scheduled appointment.

With respect to separated parents, divorced parents, and other family members bringing children to the office – this policy will still apply. The adult bringing the child to the office will be notified of any balance due and that balance must be paid prior to the appointment.

Your billing statements will be addressed from Florida Pediatric Associates, LLC. If you have any questions regarding your billing statement, please contact Florida Pediatric Associates at (727)456-3288 or toll free at (866)343-3288 for clarification.

Your signature below indicated you have reviewed and understand this policy.

_____

Parent Signature Print Name Date