7645 Cita Ln, Suite 102
New Port Richey, FL 34653
Phone (727)853-2273 Fax (727) 853-2277
http://www.caringpediatrics.com

ACCEPTANCE OF POLICIES

Patient Name: _____ DOB: _____

Patient Privacy Practices
By signing below, I am acknowledging that I have received a copy of Caring Pediatrics' Patients' Bill of Rights. I understand that it is my responsibility to read, understand and abide by the policy as presented to me.

_____ _____
Legal Guardian Date

Patient Responsibilities
By signing below, I am acknowledging that I have received a copy of Caring Pediatrics' Patient Responsibilities. I understand that it is my responsibility to read, understand and abide by the policy as presented to me.

_____ _____
Legal Guardian Date

Consent to Treat
By signing here, I am consenting to treatment of myself, or dependent, by Caring Pediatrics. I understand that my/their medical information may be viewed or shared amongst the staff of Caring Pediatrics and its business associates. Every effort will be made to protect my privacy in accordance with the HIPAA regulations.

_____ _____
Legal Guardian Date

Permission to Release Medical Information
By signing here, I authorize Caring Pediatrics to release information from my (or my child's) medical record, to my/their insurance company, third party payers or their reviewing agencies. This information will be limited to that which is necessary to expedite claim processing. The authorization is valid for every visit to Caring Pediatrics until written notice revoking this authorization is provided.

_____ _____
Legal Guardian Date

"No Show" and Cancellations By singing this I understand and agree that I will be charged $40.00 after the 2nd **"NO SHOW"**. I understand that my child will not be seen for treatment until the outstanding balance is paid in full. Furthermore, I understand that if I **"NO SHOW"** 3 times in 1 year I will be requested to find another physician. I agree and understand that I am expected to call and cancel my child's appointment 24 hour in advance or I will be charged a fee of $25.00, which will need to be paid prior to rescheduling an appointment.

_____ _____
Legal Guardian Date

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FINANCIAL GUARANTEE

Patient Name: _____ DOB: _____

If Caring Pediatrics is contracted with my insurance company, Caring Pediatrics must follow their contract and my insurances' requirements. If I have a co-pay or deductible, I must pay that at the time of service. My insurance company makes the final determination of my eligibility. It is my responsibility to know what my insurance expects and requires. Failure to pay a co pay at the time of service results in an additional fee of $5.00 for collections. I agree to pay all co pay and deductible amounts at the time of service.

We will bill your insurance as a courtesy to you. This is not a requirement for Caring Pediatrics to do so. If your insurance fails to pay any balances, it is your responsibility to pay that said balance within 30 days of the statement being sent to you. I agree to pay all balances due within 30 days of receipt of statement. I also understand that it is my responsibility to keep my address current with Caring Pediatrics.

Failure to pay a balance within 30 days will result in a **FINANCE CHARGE** on the 31st day of delinquency in the amount of two percent (2%) per month or an **ANNUAL PERCENTAGE RATE** of twenty four (24%) percent. The minimum FINANCE CHARGE WILL BE $0.50. I understand the finance charge information listed above

A re-billing fee of $5.00 will be imposed on each account that is over 30 days past due. Also if more than 1 statement is mailed to me a $5.00 fee will be added to each account due. If Caring Pediatrics calls me to collect payment at $2.00 per phone call will be imposed. I understand the additional fees imposed if I fail to meet my obligations.

I understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if my past due status is reported to a credit agency, the fact that I or my child received treatment (and all details) from our office may become a matter of public record. I understand the above listed information regarding privacy.

If Caring Pediatrics is forced to take this measure of collections via a collection agency or credit bureau reporting I agree to pay all court costs, attorney's fees, docket fees and travel fees for the physician to and from the court/attorney's office.

In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. If needed it is the responsibility if the parents to collect monies from each other. Payment is expected at the time of service regardless of which parent is accompanying the minor child to the visit.

I understand that I will need to request, in writing, and pay a reasonable copying/printing fee if I want medical record transferred to another physician or organization. Furthermore I agree that the balance on all the accounts I am responsible for will be at (0) zero, prior to any and all medical records leaving Caring Pediatrics. I am aware that payment history is part of the medical record sent to other physicians unless otherwise requested not to.

I understand that Caring Pediatrics may request a credit on my account prior to my visits if I fail to keep up with my financial obligations to their facility. The amount of the request will depend on the payment history with Caring Pediatrics.

I, _____ the parent or legal guardian of _____ date of birth_____, have read and agree to the responsibilities and obligations that are set forth to the facility of Caring Pediatrics, PA. This is a legal document to be placed in my child's chart and will be used for collection purposes if needed.

_____ _____
Legal Guardian Date