Myrtle Avenue Pediatrics 2019 Office Financial Agreement

613 S. Myrtle Avenue Clearwater Fl, 33756 250 Pine Avenue N. Suite B Oldsmar Fl, 34677

Authorization of Assignment of Insurance Benefits

Patient(s) Name: _____

Primary Insurance Name: _____ Effective Date: _____

Policy Holder's Name: _____ Co-Pay Amount: _____

ID or Policy #: _____ Group #: _____

The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical insurance status. I certify that my child has health insurance currently in force as detailed above. I assign directly to Myrtle Avenue Pediatrics all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I herby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic. I, the undersigned, agree to be financially responsible.

_____ _____

Signature of Parent/Patient Date

****Please initial after each statement that you understand and agree to abide by our policies****

I understand payment for all medical care is due at the time of service. In case of divorced parents, responsibility and payment shall be that of the guardian bringing that child in for treatment. I understand that it is my responsibility to pay any deductible, co-insurance, or any other balance not paid by my insurance company. I understand that if my account is not paid in full by my insurance within 60 days of the date of service, that I am responsible for payment I full. I understand a late fee of $30 per month will be applied to balances once they become 60 days overdue. I understand that, in case of default, I am responsible for any cost incurred in the collection of patient account, currently 30% of the balance, as well as reasonable attorney fees and court costs.

Initial: _____

If your insurance requires a co-pay, there is a $30 billing fee when the co-pay is not paid on the date of service. Your insurance requires you to pay your co-pay at every visit and we incur an expense in billing for these small balances. Therefore, we find it necessary to charge this fee. **Initial: _____**

There is a $50 return check fee for any checks returned for insufficient funds **Initial: _____**

Myrtle Avenue Pediatrics requires 24-hour advance notice for all cancellations or missed appointments. Due to staffing costs, failure to notify our office will result in a $50 fee for missed appointments, NO EXCEPTIONS. **Initial: _____**

Walk-ins outside of our walk-in hours, without a call ahead, will incur a $30 charge. **Initial: _____**

If your child receives a vaccine during his/her visit, and we are later notified that no insurance was effective for that date of service, you will be responsible for the full cost of the vaccine. **Initial: _____**

There is a $10 fee for any forms or letters requested outside the annual check-up. **Initial: _____**

I herby request and give my permission and full consent for Myrtle Avenue Pediatrics (the physicians and the staff) to provide such medical examination and treatment as they deem best for my child's physical and/or mental welfare. I will notify the physician's office of any changes in this information or permission.

****Signature of Parent/Patient**: _____ DATE_____**