Pediatric Orthopedics of Southwest Florida

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Please complete the following information regarding the patient and return it to Check-In

<u>This section is the information of the person financially responsible for the patient's care.</u>

Responsible Party Name: ______________________________ Date of Birth: _________________

Mailing Address: ____________________________________ City, State and Zip: _____________________

Phone Number: _____________________________________ Relationship to patient: __________________

Email: ____ Social Security #: _______________________

Who has legal custody of this patient? ____ same as guarantor (if other, please fill out below)

Name: ____________________________________ Date of Birth: ________________

Relationship to patient: ______________________ Contact Number: ________________

Authorization of Protected Health Information (PHI)

This form is used to authorize Pediatric Orthopedics of Southwest Florida to disclose protected health information to the person(s) designated below. <u>This will also allow these individuals (must be over 18) to bring your child for follow up appointments .</u>

Parent 1: __________________________________ Date of Birth: ________________

Relationship to patient: ______________________ Contact Number: ________________

Parent 2: __________________________________ Date of Birth: ________________

Relationship to patient: ______________________ Contact Number: ________________

Other: __________________________________ Date of Birth: ________________

Relationship to patient: ______________________ Contact Number: ________________

Privacy Practices Acknowledgement

I acknowledge receiving the privacy practices notice and have been given the opportunity to review it.

Patient Name: ___________________________________ Patient Date of Birth: _________________________

Guardian Signature: _______________________________ Today's Date: ___________________________

Pediatric Orthopedics of Southwest Florida

Financial Policy

Thank you for choosing **Pediatric Orthopedics of Southwest Florida** as your healthcare provider. We are committed to providing quality and affordable orthopedic care.

The following is a statement of our Financial Policy, which we require you to read and sign prior to treatment.

Participating Insurance Plans

We participate in many insurance plans, however if your insurance plan is not accepted by this office, payment is expected in full at the time of service. It is your responsibility to confirm with your insurance company whether our physicians are in-network providers. Please remember that an insurance policy is a contract between you and your insurance company. We are not a party to that contract.

The following information is required:
INSURANCE CARDs and a **VALID DRIVER'S LICENSE** or other form of government-issued photo identification.
We reserve the right to refuse to file claims to out of state insurance. Upon request, we can provide you with a copy of a detailed receipt, so you may file your own claim.

If your insurance plan changes, it is your responsibility to update that information with our office. Failure to do so will result in the balance of the claim becoming your responsibility.

Non-participating Insurance Plans

Patients who are insured by a carrier that our practice is not contracted with are considered self-pay. Payment is expected in full at the time of service. Upon request, we can provide you with a detailed history of your child's visit(s) so that you can submit it to your carrier. Special requests for billing insurance companies we are not contracted with may be considered at the discretion of the Practice Manager.

Referrals and Authorizations

If your insurance has designated a Primary Care Physician (PCP) and requires prior authorization for specialty care, you must ensure that we have a referral on file from your assigned PCP prior to your office visit.

If authorization is not provided, you will be asked to either reschedule your appointment or pay for the visit, in full, at the time of service.

As a courtesy, we will assist you in obtaining authorization for subsequent visits.
It is imperative that you keep our office, as well as your primary care provider, up to date with any changes in insurance information. This is your responsibility.

Financial Responsibility

A parent or legal guardian must accompany a minor on their first visit. This accompanying adult is responsible for all payments of the account. If someone other than the parent or legal guardian will be bringing the patient to subsequent appointments, they must be listed on the patient's demographic form.
They must be prepared to pay any co-pay or outstanding balance on behalf of the guarantor.

Divorced Parents of Patients

By signing this agreement, the adult who signs a minor child into our practice, accepts all financial responsibility.
This office does not forward statements or medical records, nor provide treatment updates to the other parent or legal guardian.

Payments

Payment of copays and coinsurance is expected at the time of service. We accept cash, checks, debit and credit cards.
Payments and credits are applied to the oldest charges first, except for insurance payments.

Returned Payments: A fee of **$35.00** will be added for any returned checks including stop payment checks. The balance must be paid by another form of payment. This is in addition to the original balance due.

Self-pay accounts: Self-pay patients are expected to pay in full for their charges at the time of visit; exceptions require prior financial arrangements with our billing office. Statements for Guarantor Balances will be mailed monthly and are due upon receipt.

Text Message Consent for Billing Communications: I authorize Pediatric Orthopedics of Southwest Florida to send me text messages regarding my account, including past due balances, payment reminders, and billing updates. I understand these messages may be sent via automated systems and that standard message rates may apply. I may opt out at any time by replying **STOP**. This consent is not a condition of receiving care.

Durable Medical Equipment: Durable Medical Equipment and supplies charges (cast cover, water-proof cast, sling, cast shoes, etc.) are due at the time of service. Insurance companies do not reimburse our practice for these products.

Patient Refunds: Prerequisites for patient refunds:
(1) No outstanding insurance claims on the account(s).
(2) No outstanding balances on the account(s). The account(s) show a **$0.00** balance.
Refunds will be issued for credit balances greater than **$10.00.** Credit balances of **$10.00 or less** will be held for 90 days. If the patient or guarantor does not request a refund within that time, the balance may be written off and will not be refunded. Patients are encouraged to contact our billing department if they believe they are due a refund.

Medical Records: The charge for medical records is **$1.00** per page, for the first 25 pages and **$0.25** per page thereafter, with a minimum charge of **$5.00.**

Please allow 2-3 days to obtain school forms, 1-2 days for prescription refills and 4-7 days for other requests.

X-Rays: There is a charge for X-Rays copies. CDs, containing films, are **$10.00** each.

AUTHORIZATION FOR PAYMENT AGREEMENT:

I authorize the release of all medical information necessary to process insurance claims, as well as the release of information back to my Primary Care Physician. I also authorize payment of medical benefits to **PEDIATRIC ORTHOPEDICS OF SOUTHWEST FLORIDA** for services rendered.

In the event that my insurance carrier does not pay for services rendered, I agree to pay **PEDIATRIC ORTHOPEDICS OF SOUTHWEST FLORIDA** for services provided, per the agreements stated herein.