A division of Florida Pediatric Associates, LLC

REQUEST FOR CARE AND CONSENT FOR TREATMENT

The undersigned consents to the medical care and treatment, as may be deemed necessary or advisable in the judgment of my physician or other provider, which may include but are not limited to laboratory procedures, x-ray examination, medical or surgical treatment or procedures, anesthesia, or other services Tendered to the patient under the general and special instructions of the patient's physician. Florida Pediatric Associates has the right to refuse to see you if you refuse to sign this consent or if, at any time, you choose to revoke this consent.

Patient Signature_____Date_____

ASSIGNMENT OF BENEFITS

I request that payment of authorized insurance benefits, including Medicare, if I am a Medicare beneficiary, be made on my behalf to Florida Pediatric Associates 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.

Patient Signature_____Date_____

_____ ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES INITIAL

By initialing this document, I 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.

FOR OFFICE USE ONLY:
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

__ Individual refused to sign
__ Communications barriers prohibited obtaining the acknowledgement
__ An emergency situation prevented us from obtaining acknowledgement
__ Other (Please Specify) _____

Employee Name: _____ Employee Signature: _____

_____ CONSENT FOR IDENTIFICATION PHOTOGRAPH INITIAL (*NOTE: THIS CONSENT DOES NOT APPLY IF THE OFFICE IS NOT USING AN ELECTRONIC MEDICAL RECORD)*

I consent for a photograph to be made of my child (or person for whom I am a legal guardian). I understand that the information will only be used for identification purposes and will be stored securely. Refusal to photograph will in no way affect the medical care I will receive. If I have any questions or wish to withdraw my consent in the future, I may contact the office directly.

By initialing this consent, I confirm that this consent form has been explained to me in terms that I understand. I agree to the use of this image for medical records ONLY.

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.

Signature_____Date_____