Account#_____

PEDIATRIC EYE CONSULTANTS OF NORTH FLORIDA

A Division of Florida Pediatric Associates, LLC

PATIENT INFORMATION

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

Address: _____ City: _____State: _____Zip: _____ Phone#: (____)_____

Race: ☐African American/Black ☐American Indian / 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: ☐Email ☐Mail ☐Home Phone ☐Cell Phone ☐Text Message

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

* APPROPRIATE PAPERWORK MUST BE PRESENTED AT TIME OF VISIT

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

Address: ☐Check here if same as above

_____ City: _____State: _____Zip: _____

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

☐Check this box if we may use this cell # for text and/or robocall <u>appointment reminders</u>

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#: (_____)S_____-_____ Work#: (_____)_____-_____

☐Check this box if we may use this cell # for text and/or robocall <u>appointment reminders</u>

Preferred Language:_____ Preferred method of contact:☐Email ☐Phone ☐Cell Phone

EMERGENCY CONTACTS

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

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

Jan-15

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

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.

Parent/Guardian Signature_____Date_____

LATE ARRIVALS / CANCELLATIONS / NO SHOW POLICY

Patients arriving more than 5 minutes after their scheduled appointment time may be rescheduled. Late arrivals may be seen later only if open appointment is available. If you call to alert us of your late arrival, we will try our best to work you into the day's schedule but cannot guarantee you will be seen the same day as your appointment.
Cancellation of office visits require a 24 hour notice or are subject to a $30.00 charge.
Our office also has a No Show policy of $30.00 if you miss your appointment. Excessive "No Show" visits without cancellation may result in you being discharged from our care.

I have read and understand the policy for late arrivals, cancellations and no-show visits and agree to the terms as stated.

Parent/Guardian Signature_____Date_____