FLORIDA PEDIATRIC ASSOCIATES, LLC

Pediatric Eye Consultants of North Florida

a Division of Florida Pediatric Associates

NOTICE OF PATIENT FINANCIAL RESPONSIBILITY & RELEASE OF INFORMATION

PLEASE REVIEW CAREFULLY AND ASK STAFF TO EXPLAIN TERMS THAT ARE UNFAMILIAR OR CONFUSING. SIGNATURE IS REQUIRED.

Statement of Financial Responsibility

I understand that I am responsible for the payment of this account, and hereby assume and guarantee prompt payment of all expenses incurred. In consideration of services rendered to the patient named herein, I accept financial responsibility and agree to pay charges for all services ordered by the provider(s). I understand that any balance due as a result of being uninsured or under-insured is payable immediately. I further understand that if I fail to maintain consistent payments, my account may be referred to a collection agent and/or attorney, and I agree to pay all collection related charges. I understand that if my insurance has a pre-certification or authorization requirement, it is my responsibility to notify the carrier of services rendered according to the plans provisions. I understand that failure to do so will result in reduction or denial of benefit payment and I will be responsible for any balances due.

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.

Release of Medical Information

I understand that Florida Pediatric Associates, its business associates, any treating physician/surgeon and/or my insurance company may obtain, use and/or disclose information for the purposes of treatment, payment and normal health care operations. This use and disclosure may include collection agencies and credit bureaus. Information may include psychiatric, drug abuse, alcohol and/or HIV status. I understand that if I do not consent to release of information for payment purposes, the Florida Pediatric Associates and other health care providers will be unable to bill my insurance company or other party which is or may be responsible for payment for the services documented by the withheld information, and I will be billed directly for these services. Patients with implantable devices consent to the release of their Social Security numbers to the device manufacturer to comply with the Safe Medical Devices Act. For a more detailed description of uses and disclosures for treatment, payment or normal health care operations, review Florida Pediatric Associates Notice of Privacy Practices. 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 acknowledge that I have received information regarding my rights to privacy of information under HIPAA regulations, as described in the Florida Pediatric Associates Notice of Privacy Practices.

Notice of Unauthorized, Non-Covered, or Out of Plan Services

I am aware that some services performed by Florida Pediatric Associates may be considered "non-covered" by my insurance carrier or Medicare. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I understand that if my insurance plan does not consider any service rendered a covered service or if my insurance plan has not authorized this service, they will not pay for the service rendered during this outpatient visit. I also understand and acknowledge that in the case of Out of Plan/Network services, there may be reduced benefits and I may be required to pay a larger co-payment, coinsurance or other charge. I am responsible for the entire bill or balance of the bill as determined by the practice and/or my health care insurer if the submitted claims or any part of them are denied for payment.

Waiver of "Usual, Customary and Reasonable" Clauses - (*For patients with "Out-of-Network" coverage).*

I acknowledge that the fee charged by the Practice for services rendered to me, or to the person for whom I assume financial responsibility, may exceed the fees considered "usual, customary and reasonable," due to specialized services and staff. However, I agree to pay the Practice fees in full, even if the amount is greater than what I am reimbursed from my insurance company.

For Medicare Recipients Only

I certify the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I request that payment of authorized Medicare benefits be made on my behalf to the Practice for any services furnished to me by Practice physician or other provider. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for the related services. In the case of Medicare Part B benefits, I request payment either to myself or to the party that accepts assignment.

The undersigned certifies that he/she read and understands this document and has the legal right and is duly authorized to execute this document and accepts its terms as the patient or the parent or legal guardian of the patient.

Indicate if the patient is a minor or unable to sign:

☐- Patient is a minor ☐- Patient is unable to sign because: _____

Signature of Patient or Authorized Representative: _____Date: _____

Print Name of Authorized Representative: _____

Authority of representative to sign on behalf of the patient: ☐- Parent ☐- Legal Guardian ☐- Court Order ☐- Other: _____