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ACKNOWLEDGEMENT OF FEE SCHEDULE FOR LETTERS, FORMS, MEDICAL RECORDS, AND NO-SHOW

PATIENT'S NAME: _____ **PATIENT'S DOB:** ____/____/____

Please note our policies and fee schedule for the following requests:

- LETTERS:** A service fee of \$25.00 will be charged for each official letter provided by our physicians and/ or providers of service.
- FORMS:** Parents are responsible for completing the demographic data (Name, Address, DOB, etc.) of their child before giving the form to the physician or provider to complete. The physician or provider will then complete the form after the patient has been evaluated for care. Examples of forms: FMLA, SSI, School Health, Disability Forms, Dept of Motor Vehicles, and similar forms. The fee will be \$25.00 for a one-page form and \$35.00 for multiple page forms.
- COPIES:** The fee for copies of medical records is \$1.00 per page up to 25 pages. Each additional page will be \$.25 cents as provided/ allowed by state law. ****Please note, copies of medical records only applies to information generated through Florida Child Neurology during the care and treatment of the patient.** A CD copy of in-house EEG studies will be \$25.00 per study day.

If the patient/parent/ guardian needs a copy of the latest diagnostic test, lab, or office visit for the continuation of care/treatment with another physician and/or provider, Florida Child Neurology can send the records directly to the physician—provided that the appropriate medical release forms have been signed.

The requesting party must pay fees in advance along with a signed release of medical records form (if required). This fee is an additional cost and is not billable to insurance.

All records, letters, and/or forms will be completed within 7-10 business days after payment is received. We will do everything possible to complete requests sooner. Documents may be picked up at our office or mailed. Our staff will call when the documents are ready. An additional fee of \$5.00 may be charged for postage for mailing of larger records.

“No-Show” and Cancellation Policy

* Please initial each line

- _____ A “No-Show” is a failure for the patient to show up for their appointment.
- _____ Canceling an appointment with less than 24 hour notice is considered a “No-Show” and will be charged a fee.
- _____ The fee for a “No-Show” is \$35.00 and must be paid before the next patient appointment.
- _____ Missing three (3) or more appointments within a year due to “No-Shows” or with inadequate notice may result in the patient being discharged from the clinic. Patient dismissal is at the discretion of the physician/provider.
- _____ Only emergency medical treatment will be available to the patient within the first thirty (30) days of dismissal.

I acknowledge that I have read and understand the above fees and policies.

Parent/Guardian/Caregiver Signature

Date

Printed Name

