OUR FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to the success of your treatment. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy, which were require you to read prior to any treatment.

All patients must complete our Registration and History forms before seeing the doctor. You must supply us with both your insurance card and driver's license prior to your visit.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE. WE ACCEPT CASH, VISA/MASTERCARD, DISCOVER AND AMERICAN EXPRESS.

Regarding Insurance

Regarding insurance plans where we are a participating provider.; Although we have contracted with your insurance company to provide care to their clients, your insurance policy is a contract between you and your insurance company. All co-pays and deductibles are due prior to treatment, along with a valid referral from your primary care provider, if your insurance plan requires it.

Please note that if you require treatment that is not deemed medically necessary or is not a covered service with your insurance carrier, you will be responsible for payment in full prior to that treatment. In the event that your insurance coverage changes to a plan where we are not participating providers, refer to the paragraph below.

Regarding insurance plans where we are not a participating provider: You are responsible for payment of your first office visit in full. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract.

If your insurance company has not paid your account in full within 45 days, you will be responsible for payment within 30 days upon receipt of the bill. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurance. You are responsible for these charges. We bill secondary insurance carriers as a courtesy to our patients.

Usual and Customary Charges

Our practice is committed to providing the best treatment for our patients. We charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. You will be responsible for payment if your insurance carrier authorizes and certifies care but fails to pay as agreed.

Interest

We reserve the right to charge interest in the amount of 18 % per year as provided by state law on past due accounts.

Minor Patients

The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For an unaccompanied minor, non-emergency treatment will be denied unless payment arrangements have been made in advance.

Missed Appointments

Unless canceled at least 24 hours in advance, we may charge a fee of $25.00 for missed appointments. This is not covered by insurance. Please help us serve you better by keeping scheduled appointments.

Returned Checks

If your bank returns your unpaid check for any reason, such as insufficient funds or closed account, you will be charged $25.00. Payment must be made prior to your return to the office and we may not accept any more personal checks.

Billing Questions

Please address all billing questions to Florida Pediatric Associates at 727-456-3288 or toll free 866 343-3288.

Collections

You may be dismissed from the practice if you fail to meet your financial responsibilities and/or we must use a collection agency to bring your account up-to-date. If it is necessary to turn the account over to collections and you wish to return to the practice, you will be responsible for all charges, including those incurred to collect the amount owed, i.e. collections agent's fees. Your account must be paid in full before you are able to return to the office.

_____
Signature of Responsible Party

_____
Date

_____
Witness

_____
Date