1530 Celebration Boulevard, Suite 301, Celebration, Florida 34747
Phone (407) 566-9700 Fax (877) 534-5105

CELEBRATION PEDIATRICS
BILLING AND FINANCIAL POLICY

_____ _____
Patient Name Date

Please initial in the space provided and sign your name acknowledging your consent and agreement.

Insurance: _____(initial)

If you have insurance, we will provide insurance claim filing for the insurance plans with which we participate; however, if we do not accept your insurance plan or if a **claim is denied or a balance is due, you are responsible for payment of the balance owed and we expect payment within 30 days from the date we notify you of such determination. It is your responsibility to pay any co-pay's, deductible, co-insurance or any other balance not paid for by the insurance or third-party payer within 30 days**.

It is the responsibility of the patient/guardian to provide us with current insurance plan information prior to services rendered for accurate billing of services to be filed. You are also responsible for contacting your insurance company to make sure we are in network with your particular plan. It is important that you are familiar with the guidelines of your plan requirements regarding authorizations, deductibles, co-payments and other vital requirements.

In consideration of services rendered, you agree to transfer and assign to Celebration Pediatrics all rights, title and interest in any payment due to you or otherwise payable to you for services rendered.

Self Pay: _____(initial)

In consideration of the services rendered, you agree to pay Celebration Pediatrics in accordance with the regular rates and terms of service/costs for Celebration Pediatrics. Payment is due in full at the time services are rendered. You affirm that you are duly authorized as the patient or as patient's guardian/agent to execute this document and accept its terms.

Medicare/Medicaid: _____(initial)

Patient's certification authorization to release information and payment request. You certify the information given to Celebration Pediatrics in applying for payment under Title XVIII/XIX of the Social security act is correct. You authorize any holder of medical or other information about you to release to Social Security Administration/Division of Family services or its intermediaries or carriers any information needed for this or a related Medicare/Medicaid claim. You further certify all insurance proceeds pertaining to treatment or services provided shall be assigned to Celebration Pediatrics.

Laboratory Charges:_____(initial)

We collect and send specimens to a laboratory for processing. We are NOT responsible for laboratory charges. If you have any questions regarding the laboratory charges, you must call the laboratory listed on your bill.

Office Charges: _____(initial)

Credit Cards: For your convenience, we will keep your credit card information on file to be used for balances on your account that are your responsibility (co-insurances, c0-pays, and deductibles, not to exceed $150.00

FMLA: There is a $25 fee for FMLA paperwork. This fee is due **PRIOR** to any paperwork being faxed or picked up. There is a $50 fee for expedited FMLA paperwork.

Returned Check Fee: A **$35.00 fee** will be assessed to your account for any returned checks

No Show Policy: A **$25.00 fee** will be assessed to your account for any "NO SHOW" or CANCELLATION on a same day SICK appointment. All future appointments require a 24-hour cancellation notice PRIOR to the appointment or the **$25.00 fee will apply**.

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Office Charges Continued

Tele-Care Call Policy: All calls after normal business hours requesting medical advice will be referred to the Arnold Palmer's Tele-Care Nurse Program. There is a **$20.00 fee per call** for this service. ***This fee is YOUR responsibility. This service is NOT covered by any insurance plan.***

Collections/Past due Accounts: _____(initial)

You understand and agree that all accounts must be brought current within 30 days of the service that was rendered. Once your account is assigned to outside collections a late fee $50.00 collections processing fee will be added to your account. After 60 days the account will be turned over to our attorney for collection.

Should this account be referred to an attorney for collection, you will be responsible for reasonable attorney's fees, court costs, recording fees and collection expenses. You further agree that exclusive venue for any collection action shall be in Osceola County, Florida.

You authorize Celebration Pediatrics and hereby give all of its affiliated entities, employees, agents and Independent Contractors permission to call you through the use of dialing equipment artificial voice or similar technology, even if you are charged for the call. You expressly agree that such automated calls may be made by Celebration Pediatrics and all of its affiliates, contractors and agents. With such consent, you specifically waive any claim you may have against Celebration Pediatrics, its affiliates, contractors and/or agents for making such calls, including any claim under the Telephone Consumer Protection Act. You also expressly agree that this provision applies to the use of text messaging. You authorize

Celebration Pediatrics, its affiliates, contractors and/or agents to use any cell phone or other telephone number to contact you for any purpose, including collection of an outstanding invoice at the number set forth below. If you have a change in address or telephone number, it is your responsibility to provide Celebration Pediatrics with your updated contact information.

I have read, understand and agree to Celebration Pediatrics' Billing and Financial Policy:

_____ _____
Patient Name Patient Date of Birth

_____ _____
Parent/Guardian Printed Name Date

➡ _____
Parent/Guardian Signature

_____
Telephone Number for Receiving Calls

_____
Telephone Number for Receiving Texts