Peninsula Pediatrics
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PeninsulaPediatricsFL.com

Financial Policy and Agreement

Patient Name: _____ D.O.B._____

I understand and agree with the following financial policy of Peninsula Pediatrics of West Florida (Peninsula Pediatrics):

1) Payment for all co-payments, co-insurance and deductible are to be paid at the time of service. Peninsula Pediatrics accepts cash, checks, debit cards and credit cards as methods of payment.
2) As the guarantor, I will be responsible for all charges that are not covered by my insurance company. If my insurance is terminated, I (as the guarantor) will be responsible for all charges incurred with Peninsula Pediatrics.
3) As the guarantor, I am financially responsible for my newborns first visit to Peninsula Pediatrics unless I can show proof of the insurance.
4) I will notify the office of any change of address, phone number and insurance information at the time of each visit.
5) I authorize submission of a claim and direct payment to Peninsula Pediatrics for all services provided to the above patient. When a claim is submitted as an unassigned claim, I also authorize payment to be issued directly to Peninsula Pediatrics for the amount due in my pending claim for services of medical treatment to the above patient.
6) If my child needs to be seen by a specialist, I must obtain proper authorization and understand that I am financially responsible to the specialists. I must call the specialist and make the appointment and notify Peninsula Pediatrics of the appointment to ensure that proper authorization is obtained with a 48 hour advanced notice.
7) In the event I can't be present during a visit, I will send written authorization with the adult/ guardian that is with my child.
8) If there is a balance on my account, I will pay the balance in full within 30 days. I understand that if the balance is 30 days past due I will be charged an administration fee of $25.00 each month until the balance is paid in full.
9) In the event that my account is sent to an outside collection agency, a 35% collection fee will be charged to my account before it is turned over to a collection agency. If my account is sent to an outside collection agency, I will be dismissed from the practice.
10) In the event you do not show up for a scheduled appointment (No Show), a $25.00 fee will be assessed on the above patients account. After 3 No Shows you may be dismissed from the practice.
11) I understand that Peninsula Pediatrics doesn't accept secondary insurances and it is my responsibility to bill my secondary insurance company.

Peninsula Pediatrics is committed to providing the best treatment for our patients and we charge what is considered "usual and customary fees" for our demographic area. You, as the guarantor, are responsible for payment if there is any private insurance companies' arbitrary determination of "usual and customary" fees or rates.

I have read the Financial Policy of Peninsula Pediatrics and I understand and accept it.

Signature of Parent/Guardian/Legal Representative: _____ Date: _____

Signature of Witness: _____ Date: _____