ANGEL KIDS PEDIATRICS PRIVACY NOTICE ACKNOWLEDGEMENT AND FINANCIAL AGREEMENT

PRIVACY NOTICE ACKNOWLEDGEMENT

I acknowledge that I have had the opportunity to review a copy of the Angel Kids Pediatrics Privacy Notice. I understand that I am responsible to read this Notice and notify Angel Kids Pediatrics, in writing, of any request for restrictions in the use or disclosure of my child's individually identifiable health information. I understand the notice included electronic access to my child's medical history. Angel Kids Pediatrics has the right to revise this Notice at anytime and will post a copy of the current Notice in the office in a visible location at all times and on their website at www.myangelkids.com. Angel Kids Pediatrics will provide me with a copy of its most recent Notice upon my request.

Patient name: _____ Date of Birth: _____/_____/_____

Parent, Guardian or Legal Representative Signature:

_____

Person(s) authorized to have access to child's records:
Name: _____ Relationship: _____

Name: _____ Relationship: _____

FINANCIAL RESPONSIBILITY

I understand that in consideration of the services provided to the patient, I am directly and primarily responsible to pay the amount of all charges incurred for services (including laboratory testing and radiology) and procedures rendered at Angel Kids Pediatrics. I am responsible for any applicable deductible, co-insurance or co-payments prior to the provision of services.
Angel Kids Pediatrics may file a claim for payment with my insurance company as required by contractual agreement. If the insurance company fails to pay Angel Kids Pediatrics in a timely manner for any reason, then I understand that I will be responsible for prompt payment of all amounts owed to Angel Kids Pediatrics. Should the account be referred to a collection agency or attorney for collection, the undersigned shall pay all costs of collection, including a reasonable attorney's fee.
The billing department and/or office mangers handle financial matters, not the doctors. Please direct your questions accordingly.
Settlements/financial responsibilities, such as divorce, must be resolved between parents. We do not get involved with these issues.

RESPONSIBILITY TO PROVIDE PROOF OF INSURANCE

I understand that it is my responsibility to provide Angel Kids Pediatrics with a copy of my child's **current insurance card.** If I do not have insurance, I will be considered a Private Pay (or Self Pay) patient and I am financially responsible for the total amount of the services provided. **I will notify Angel Kids Pediatrics immediately upon any change in my insurance.**

CONSENT TO TREAT

I hereby consent and authorize the performance of all appropriate procedures and course of treatment, the administration of all anesthetics, and any and all medication which in the judgment of my provider may be considered necessary or advisable for my child's diagnosis and/or treatment.

ADDITIONAL INFORMATION

Angel Kids Pediatrics accepts payments in: Cash, Check, Debit and Credit Cards.
I understand additional charges ($25.00) are applied to my account for any returned checks used to pay on my account. I may also be charged if I do not cancel my scheduled appointment, for not paying my co-pay and/or co-insurance or patient responsibility including deductible at the time of service, and for other administrative expenses not covered by my insurance plan.
In the event I receive payment from my insurance carrier, I agree to endorse any payment due for services rendered to Angel Kids Pediatrics.

FORM FEE

For special forms to be completed, you will be charged $25.00 per form. Physical and shot record forms requested after the well-exam visit will incur a charge of $10.00 per set. This fee must be paid in full prior to receiving the completed forms. Angel Kids Pediatrics will not hold the liability of faxing or mailing any forms. Please give us 48-72 hours notice when requesting forms so that we have adequate time to prepare them.

IN-NETWORK INSURANCES

AETNA PPO, HMO, (COVENTRY-PPO/Meritan Health ONLY-DR. AFFAN ONLY), AVMED, ASSURANT, BCBS (BLUECARE, BLUE OPTION, FLORIDA BLUE, TRADITIONAL PLANS), CAMBRIDGE PPO (INTERGRATED HEALTHPLAN), CIGNA PPO (GREATWEST/PHCS), GOLDEN RULE, HUMANA, MMSI, TRICARE (PRIME/STANDARD/RETIRED), UMR, UNITED HEALTHCARE PPO ONLY, SUNSHINE (MEDICAID/HEALTHYKIDS-STARS-STARSPLUS),MOLINA HEALTHCARE MEDICAID, ALLSTATE (AUTO ACCIDENTS ONLY- NEED CASE#), DAIRYLAND (AUTO ACCIDENTS ONLY-NEED CASE#), GEICO (AUTO ACCIDENTS ONLY-NEED CASE #), DIRECT GENERAL (AUTO ACCIDENTS ONLY NEED CASE #), SMARTHEALTH (LOCAL BCBS-DR. AFFAN ONLY PPO), PROGRESSIVE (AUTO ACCIDENT ONLY NEED CASE#), GEHA PPO, GREAT WEST PPO, HEALTHPARTNERS PPO (DR. AFFAN ONLY), MAYO PPO (ONCE CLAIM IS FILED PT'S PCP WILL FALL UNDER TAXID), MOAA, ONENET PPO (DR. AFFAN ONLY), OXFORD HEALTH (DR. AFFAN ONLY), RSL SPECIALTY, CORESOURCE PPO (DR. AFFAN ONLY), MVP (DR. AFFAN-ONLY), PHCH PPO, MULTIPLAN PPO, STATE FARM (AUTO ACCIDENT ONLY CASE# NEEDED), UHS SERVICES (DR.AFFAN ONLY), HEALTHEASE KIDS (WELLCARE/STAYWELL AGES 3-17 ONLY), HUMANA PPO
OUT OF NETWORK PLANS GATORCARE (BCBS-SHAND/UFHEALTH), UNITED HEALTHCARE HMO/COMPASS/COMMUNITY MEDICAID/HEALTHYKIDS, AETNA (HEALTHSCOPE)
***ALL INSURANCES WE ACCEPT ARE SUBJECT TO CHANGE WITHOUT NOTICE.**

ASSIGNEMENT OF BENEFITS

I hereby authorize and assign all payments and/or insurance benefits for medical services and/or surgical procedures rendered to patients, directly to Angel Kids Pediatrics. I hereby authorize Angel Kids Pediatrics to release medical information necessary to obtain payment. I understand that I am financially responsibly for all changes not covered by my insurance plan.

SIGNATURE

BY SIGNING THIS AGREENMENT, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDIITIONS.

Patient's Printed Name: _____ Patient's Date of Birth: _____/_____/_____

Parent, Guardian or Legal Representative Signature: _____ Date Signed: _____/_____/_____