Small World Pediatrics, P.A.

2527 Windguard Circle, Ste 102, Wesley Chapel, FL 33544
Phone (813) 907-8001 • Fax (813) 907-5744

FINANCIAL RESPONSIBILITY & ACCOUNT INFORMATION

GUARANTOR STATEMENT OF FINANCIAL RESPONSIBILITY:
I understand that I am responsible for the payment of this account, and hereby assume and guarantee prompt payment of all expenses incurred. Coinsurance and copayments are due at the time of service. A **No Show Fee of $25** will be applied to my account for Missed appointments or a Cancellation less than 24 hours prior to my child's appointment. If I need to **Cancel** an appointment, I must **call 24 hours prior** to the appointment to either cancel or reschedule. If my child has **three** (**3) or more No Shows in a 12 month period**, my child may be **discharged** from our practice. Last minute cancellations will be evaluated on a case-by-case basis and may be considered a No Show at the Physician's and/or the Manager's discretion.

_____ **(INITIALS)**

NOTICE OF "NON-COVERED" SERVICES:
I am aware that some services performed by Small World Pediatrics, P.A. may be considered "non-covered" by my insurance carrier. Therefore, I may become fully responsible for payment of these services.

WAIVER OF "USUAL, CUSTOMARY, AND REASONABLE" CLAUSES:
(For patients with "UCR" coverage) I acknowledge that the fees charged by Small World Pediatrics, P.A. for service rendered to me, or to the person for whom I assume financial responsibility, may exceed the fees considered "usual, customary, and reasonable," due to specialized services and staff. However, I agree to pay Small World Pediatrics, P.A. fees in full, even if the amount is greater than what I am reimbursed for from my insurance company.

BILL TO/PAYMENT INSTRUCTIONS:
_____ COMMERCIAL INSURANCE/THIRD PARTY PAYOR _____ MEDICAID
(INITIALS) **(INITIALS)**

ASSIGNMENT OF INSURANCE BENEFITS/AUTHORIZATION TO RELEASE INFORMATION:
I hereby authorize direct payment of medical office/hospital benefits to Small World Pediatrics, P.A., for services rendered. I understand that I am financially responsible for any balance not covered by my insurance and for payment regardless of insurance pending. I hereby authorize Small World Pediatrics, P.A., to release any medical or incidental information that may be necessary to process and/or adjudicate the claim.

PERMISSION FOR TREATMENT:
Permission is hereby granted for physicians, employees or agents of Small World Pediatrics, P.A. to render the patient named below such medical and surgical treatment as deemed necessary.

NOTICE OF PRIVACY PRACTICES:
I acknowledge that I have been provided with Small World Pediatrics, P.A. Privacy Practices that provides a description of Protected Health Information uses and disclosures. I understand that I have the right to review the Notice of Privacy Practices prior to signing this statement. I understand that Small World Pediatrics, P.A. reserves the right to change its Notice of Privacy Practices that will be effective for the health information Small World Pediatrics, P.A. already has about me, as well as any they receive in the future. Small World Pediatrics, P.A. will post a current copy of the Notice. I understand that I may obtain a copy of the current Notice in effect upon request.

My signature below acknowledges that I have read all of the above and understand/agree to all provisions therein regarding the Guarantor's responsibility for payment, permission for payment, and permission for treatment.

My signature below acknowledges that I have received the Small World Pediatrics, P.A. Notice of Privacy Practices.

Patient's Name: _____ Date: _____ /_____ /_____
Parent/Legal Guardian (Signature) _____ Relationship to Patient: _____
If refusal to sign, staff member's/witness' signature: _____
Date of Attempt: _____ /_____ /_____

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