FINANCIAL POLICY

Sunshine Pediatrics of Ocala, P.A. is committed to providing your child with the best possible care and will be pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions regarding our fees, financial or your relationship.

Fees for service- I understand that my insurance carrier may require an authorization for services provided by Sunshine Pediatrics of Ocala, P.A. If for any reason my insurance company does not authorize services incurred by the patient, I will be responsible for all charges incurred.

Cancelled appointments- Please be courteous and cancel or re-schedule your appointment at least 24 hours in advance or you may be subject to cancellation fee.

Self-pay- Payment in full is expected at the time of service.

Insurance- This practice participates with the following carriers: **Aetna, Avmed, BCBS, Cigna, HPSE, USA Benefits, United Healthcare, Healthykids, CMS, Prestige, Staywell, and Sunshine State Health Plan.**

If you are a member of one or more of the carriers listed above, we will file a claim to your carrier, however, you will be expected to pay the co-pay. Coinsurance and/or deductibles are due at the time of service.

If you are a member of any insurance that is not listed, you are expected to pay in full at the time of service and we will provide you with the necessary forms to file with your insurance carrier for reimbursement.

Release of Information: I, the below named parent or guardian of the patient named below do hereby authorize **Sunshine Pediatrics of Ocala, P.A**. to release to any third party payer or provider of care any and all medical information and records concerning diagnosis, treatment in connection with determining a claim for payment for such treatment and/or diagnosis required by a third party provider in assessment, planning and/or implementation of care.

Agreement

I agree that should the amount of insurance benefit be insufficient to cover the expenses, I will be responsible for payment of the difference. I will be responsible for the entire amount due (excluding disallowed amounts per a managed care contract) for services rendered if the expenses are not covered. Under the policy, I understand that **Sunshine Pediatrics of Ocala, P.A**. will not be involved in disputes between me and my insurance company regarding deductibles, co-payments, covered charges and/or usual and customary charges other than to supply factual information as necessary.

The undersigned will be pay all cost and expenses including a reasonable attorney fee incurred or paid by **Sunshine Pediatrics of Ocala, P.A.,** in the collection of this obligation by suit or otherwise the entire amount is due and payable upon billing.

This agreement shall remain in effect until revoked by me in writing. I also permit Sunshine Pediatrics of Ocala, P.A. to use a photocopy of these assignments to be used in place of the original on file at **Sunshine Pediatrics of Ocala, P.A.**

Parent or Guardian Signature: _____ Date:_____