TRINITY PEDIATRICS, INC.

2131 S.W. 22nd Place · Suite 202
Ocala, Fl 34474

Thank you for choosing our office! In order to serve you properly, we need the following information, please print. All information will be kept confidential.

PATIENT REGISTRATION

Patient Name ______________________________ D.O.B. ______________

SSN ________________ ☐ Male ☐ Female Home Phone ______________

Address ______________________ City ______ State ____ Zip Code ______

Name of School ______________ City ____________ State ______________

How did you hear about us? Insurances ___ Hospital ___ Individual __________

Magazine ___ Internet ___ Other _____

Person to contact in case of emergency ______________________________

Relationship to Patient ____________________ Phone____________________

GUARANTOR INFORMATION

Mother/Guardian __________________________ D.O.B. ______________

SSN ______________________________ Home Phone ________________

Address ____

City ______________________________ State __________ Zip __________

Name of Employer ____________________ Work Phone _________________

Father/Guardian __________________________ D.O.B. ______________

SSN ______________________________ Home Phone ________________

Address ____

City ______________________________ State __________ Zip __________

Name of Employer ____________________ Work Phone _________________

Authorization Release

I authorize the release of any information concerning my child's health care, advice and treatment provided for the purpose of evaluating and administrating claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

____________________________ ____________________________

Signature of Responsible Party/Guarantor Date

TRINITY PEDIATRICS, INC.

2131 S.W. 22nd Place • Suite 202 • Ocala, Fl 34471 • (352) 369-3700 • Fax (352) 369-3931

Financial policy

Trinity Pediatrics, Inc.'s Doctors are committed to providing you with the best possible care and we are pleased to discuss our professional fees with you at anytime. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees or financial policy.

RELEASE OF INFORMATION - I , the below named patient, do hereby authorize Trinity Pediatrics, Inc.'s Doctors or any assistant of theirs to release to any third party provider (such as an insurance company, government agency, physicians, or hospital) any medical information concerning my treatment, for its use in connection with determining a claim for payment for such treatment and/or diagnosis, continuation of care for such treatment.

MEDICAID/MEDICARE - Patient certification authorization to release information and payment request. I certify that the information given by me in applying payment under title IXII/XIX of the SOCIAL SECURITY ACT is correct. I authorize any holder of medical or other information about me, to release to the SOCIAL SECURITY ADMINISTRATION/DIVISION OF FAMILY SERVICES or its intermediaries or carriers, any information needed for this related MEDICAID/MEDICARE Claim. I understand that I am responsible for any health insurance deductible and co-insurance; I hereby *certify* that all MEDICAID/MEDICARE benefits shall be assigned to Trinity Pediatrics, Inc.'s Doctors.

It is not the policy of this office to accept MEDICAID as a secondary payer, except in those cases where MEDICARE is the primary payer.

CANCELED APPOINTMENTS - Patients, who do not cancel confirmed appointments, will be charged a NO-SHOW fee of $25.00 for each missed appointment. Insurance Companies are not responsible for payment of these charges.

AUTHORIZATION FOR SERVICES - I understand that my Insurance Company may require an authorization for services incurred by me, I will be responsible for any and all charges.

FEES FOR SERVICES - Office charges are based on the amount of time spent on decision making for each patient and an actual charge can only be determined after services performed. Any fees explained to me prior to services are estimated fees only.

CHILDREN OF DIVORCED PARENTS - Payments due at time of service, no matter who is responsible by order of the divorce decree.

PLEASE READ AND SIGN BACK OF PAGE

INSURANCE PAYMENTS - Our insurance policy is a contract between you and your insurance company. We are not a party to the contract. As a service to our patients, we may accept assignment of insurance benefits. We will file claims for you, however, we so require 20% co-insurance and deductible to be paid at the time of service. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us accurate insurance information. We will assist your insurance company with additional information they may need in order to pay your bill. We will file secondary insurance, if provided with the necessary information. Regarding insurance plans where we are the PROVIDER, all co-pays and deductibles are due at the time of service. In addition, if your plan is an HMO Plan, our office MUST be listed as your PRIMARY CARE PROVIDER (PCP) on your insurance card. In the event your insurance coverage changes, please notify us in advance or you will be responsible for payment of services denied by your insurance plan. We will NOT become involved in disputes between you and your insurance company regarding deductibles, co-pays, covered charges, or usual customary charges other than to supply factual information as necessary.

SELF-PAYING PATIENTS/CREDIT TERMS - all fees for services will be due, and payable, at the time of services rendered. **NO** credit will be extended without prior approval of the **OFFICE MANAGER**, or the **MEDICAL DIRECTOR**. Approval should be made in advance of treatment, however, emergency credit may be extended on a **CASE-BY-CASE** basis after services are rendered. All credit amounts must be paid within 30 days of service.

RETURNED CHECKS - Returned checks for insufficient funds will be returned to the patient only *after acceptable* payment has been made. There will be a $25.00 service fee attached to all returned checks. If the check and ALL related charges cannot be collected within 14 days of notice to patient, we will refer this matter to the State Attorney's Office or Small Claims Court. The amount of the check and all related charges MUST be paid in cash or money order.

MISCELLANEOUS - Patients who will not pay their bills will be dismissed from this practice in writing and Emergency only care will be provided for thirty (30) days after dismissal, to allow time for same to find a new Physician.

AGREEMENT - I agree that should the amount of the insurance benefit be insufficient to cover the expense, I will be responsible for the payment of the difference, I will be responsible for the entire amount due for services rendered if the expanse is not covered under my policy. I authorize Trinity Pediatrics Inc. to submit insurance claims on my behalf. I am aware that this service is being provided as a courtesy. I understand that I will be financially responsible for all services that are not paid in full within 45 days of service regardless of any reason given by the insurance company. If this account should become delinquent and/or past due after 90 days, I agree to pay all the costs of collection including, but not limited to, court costs, sheriff fees, collection agency fees, attorney's fees, and interest from the date of service in the amount of 18% per annum (1.5% per month).

____ Date ____________________

PARENT OR LEGAL GUARDIAN SIGNATURE

Thank you for understanding our financial policy. Please let us know if you have any questions.

CONSENT FOR TREATMENT

I hereby consent to the medical treatment at Trinity Pediatrics, inc., by its doctors and staff.

____ Date ____________________

PARENT/GUARDIAN SIGNATURE

TRINITY PEDIATRICS, INC.
2131 SW 22ND PLACE
SUITE 202
OCALA, FL 34471
PHONE (352) 369-3700
FAX (352) 369-3931

Date:___________________

If you are unable to keep your appointment, kindly give our office a 24 hours notice so another patient may use this time. There is a $25.00 charge per patient for missed appointments. It is your responsibility to pay the $25.00 fee **NOT** the insurance company. **(MEDICAID/HEALTHEASE/PRIVATE).**

I AGREE TO PAY ALL COSTS INCURRED AT THIS OFFICE IN THE *EVENT* THAT THE PATIENT(S) MISSED AN APPOINTMENT WITHOUT NOTIFYING THE RECEPTIONIST OR CALLING TO RESCHEDULE.

Parent/Guardian Signature:______________________________

Thanks for your cooperation.

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PRIVACY PRACTICE ACKNOWLEDGEMENT

Acknowledgement Form:

I have received the Notice of Privacy Practices and I have been provided an opportunity to review all forms.

Child's Name:______________________Child's Date of Birth:__________

Circle One: Parent or Guardian:___________________________________

Today's Date:________________