Internal MEDicine & PEDiatrics
MEDPEDS ASSOCIATES OF SARASOTA, PA

CONSENT FORM

Medpeds Associates of Sarasota, PA
1931 S. Tuttle Ave., Sarasota, FL 34239
Phone (941) 955-8800 ~ Fax (941) 955-8842

May we leave messages & lab results on your home answering machine or with a family member? ___YES ___NO

Family Member:

_____

Full Name **Relationship**

Financial Policy:
I understand that I must provide MedPeds Associates with my insurance card at each and every visit and as a courtesy to me, Medpeds will file a claim to my insurance company with the insurance information I have provided. I accept responsibility for the remainder of charges that are not fully reimbursed by my insurance company or for amounts deemed to be my responsibility by my Managed Care Plan and I understand that payment of these amounts will be due upon receipt of a billing statement. The initial statement for patient responsibility will not have an assessment. The second and final statements will be assessed a **$10.00 rebilling service charge each month**. If incorrect or incomplete insurance information is given at the time of service, I will be responsible for the full charges incurred and realize it is my responsibility to contact my insurance company to resolve the issue. Co-payments, deductibles and outstanding balances are due prior to time of service; otherwise, I understand the appointment will be rescheduled. I understand that if no insurance is to be billed, payment in full is expected at the time services are rendered. If payment is not made at time of service and a statement is required to be sent out, there will be a **$10.00 service charge** assessed. *Cancellation Fees*: Cancellation of appointment prior to appointment time ***(at least 24 hours in advance)*** is required; otherwise, there is a **$25.00 no show/cancellation fee** for reserving unused time with the doctor**.** Appointments made same day and cancelled same day are subject to a **$25.00 no show/cancellation fee**. *Insufficient Funds*: Returned checks will have a **$35.00** check fee added and must be paid prior to any pending appointments. *Non Payment of Services*: In the event that it is necessary for my account to be sent to an outside collection agency, I understand that I will be responsible for a **30% collection handling charge and any associated collection fees**. In addition, I understand that I will be dismissed from the practice along with all family members**.** Any further contact or correspondence regarding the account, will be directed to and handled by the outside collection agency. *Medical Records*: I understand I may obtain a copy of my Medpeds medical records, after providing 72 hours notice and a **$5.00 fee** has been collected. All records are provided via cd.

Consent for Treatment: I authorize the physicians of MedPeds Associates of Sarasota, P.A. to provide medical care and treatment for my dependent or me.

Photo Documentation: To provide excellent care to its patients, MedPed's Associates of Sarasota, P.A. uses photography for patient identification and documentation of physical findings. I, the undersigned, understand that all photo-documentation becomes a part of the medical record.

Insurance Verification: I understand it is my responsibility to present my insurance cards and photo ID upon each and every appointment.

Assignment of Benefits: I request that payment of insurance or authorized Medicare benefits be made to MedPeds Associates of Sarasota, P.A. for any services furnished to me by that provider. I authorize any holder of medical information about me to release to my insurance company, the Center for Medicare and Medicaid Services, or any agent for these entities any information needed to determine benefits or the benefits payable for related services. I certify that the information given by me to MedPeds Associates of Sarasota, P.A. in applying for payment by my insurance or under the Medicare or Medicaid program is correct and complete. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Release of Medical Record: By my signature below, I am authorizing the release of my Protected Health Information to MedPeds Associates of Sarasota, P.A. Furthermore, to ensure proper follow up and continuity of care, I authorize MedPeds Associates of Sarasota, P.A. to release my Protected Health Information to other healthcare providers (including, but not limited to: specialists, diagnostic testing centers, laboratories, and hospitals) to which I may be referred or from which I may be receiving concurrent care.

Acknowledgement of Receipt of Notice of Privacy Practices: I have received a copy of the Notice of Privacy Practices for MedPeds Associates of Sarasota, P.A. that describes how my health information is used and shared. I understand that MedPeds Associates of Sarasota, P.A. has the right to change this notice at any time. I may obtain a current copy by contacting MedPeds Associates of Sarasota.

Email Correspondence Authorization: In compliance with the HIPAA privacy rule, by signing below, I'm *authorizing in advance* use of my confidential email to receive Medpeds email notifications regarding future appointments as well as disease-specific health-related products/services. See our privacy policy. **CONFIDENTIAL EMAIL**_____@_____

Hospital Services: I understand that the physicians of MedPeds Associates of Sarasota, P.A. have admitting hospital privileges at Sarasota Memorial Hospital. They do not provide inpatient services at any other hospital, nursing home, or any other healthcare facility. When transferred or admitted to an alternative institution, I understand that I will be under the total care of the admitting facility's physician.

_____ _____
PRINT Patient Name **Date**

X_____ _____
SIGNATURE of Patient/Guarantor **Relationship to Patient**

Rev 12.23.10