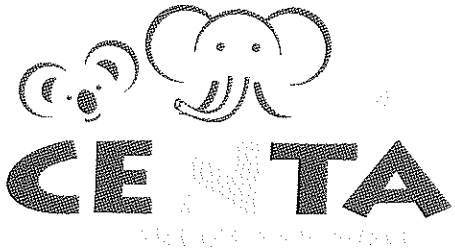


Office Policy

Patient Name: _____ **D. O.B:** _____

Thank you for choosing Children's Ear, Nose, Throat & Allergy. It is our goal to provide you with the best possible care. Please review our policies and guidelines outlined below. Your cooperation with our policies will enable us to serve you in the best possible manner.

Office Payment Policy and Billing Questions

Payment is expected **in full** at the time services are rendered by the person accompanying the child for treatment. If our office is a participating provider with your insurance carrier, all non-covered services, co-pays, and/or deductibles will be collected at the time of each visit. Arrangements for anything other than full payment at the time of service must be made prior to your appointment. It is the responsibility of the guarantor to understand and accept the guidelines set up within the individual's insurance plan. If you are unable to provide us with complete insurance information at the time of your visit you will be responsible for payment of services in full. Please obtain insurance authorizations and/or referrals (if necessary) prior to your visit to avoid delays or rescheduling.

For billing questions, please contact our billing office for clarification:
Patient Last Name **A-L** call Elizabeth Forziano 727-322-7935
Patient Last Name **M-Z** call Christy Kelly 727-456-4259

Diagnostic Testing

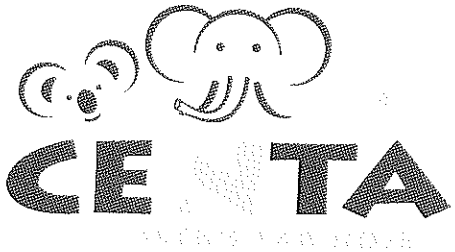
Please complete all prescribed diagnostic testing in a timely manner (7-10 days unless otherwise specified). If your insurance plan denies any lab test, x-ray, surgery, or other diagnostic exam that is prescribed we ask that you notify our office as soon as possible. If an appeal letter is requested we will be happy to provide it, however, your insurance company may still choose to deny coverage even with an appeal letter.

Late Arrival/Cancellation

Patients arriving more than **15 minutes** after their scheduled appointment time may be rescheduled. Occasionally late arrivals may be seen at the end of the clinic **at the Physician's discretion.** If you call to alert us of your late arrival we will try our best to work you into the day's schedule but cannot guarantee you will be seen that day. We appreciate your compliance with this in order to avoid long waits. Cancellation of office visits and in-office procedures need to be cancelled **the business day prior** or are subject to a **$25.00 charge**. Surgery cancellations other than illness need to be cancelled **the business day prior** or are subject to a **$100.00 charge**. Excessive "no show" visits without notification may result in the discharge of the patient from this clinic.

Medical Records

Medical records may be copied upon written request for **$1.00 per page**. There is no charge for medical records sent directly to another health care provider. You will be asked to sign a release of information prior to the records being sent.



HIPAA

Our Notice of Privacy Practices, required by HIPAA, is attached for your review. You may wish to save a copy for your records. This document is also available in our office.

Assignment of Benefits/Guarantor Agreement

I request that payment of authorized insurance benefits be made on my behalf to Florida Pediatric Associates, LLC for any medical services provided to me by that organization. I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related equipment or services to the organization, the Health Care Financing Administration, my insurance carrier or other medical entity.

A copy of this authorization will be sent to the Health Care Financing Administration, my insurance company, or other entity if requested. The original will be kept on file by the organization.

I understand that I am financially responsible for any balance not covered by my insurance carrier. It is my responsibility to notify the organization of any changes in my health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the organization and/or my health care insurer if the submitted claims or any part of them are denied for payment.

I understand that by signing this form I am accepting responsibility as explained above for all payment for products and services received. I further understand and agree that if I fail to make timely payments on my account, I will be responsible for any and all reasonable costs of collection, including filing fees as well as reasonable attorney's fees.

I acknowledge that I have received a copy of the organization's Notice of Privacy Practices. This acknowledgement is required by the Health Insurance Portability and Accountability Act (HIPAA) to ensure that I have been made aware of my privacy rights.
I have read and understand the office policy for payment and agree to the terms as stated.

Signature: _____ Date: _____