2021 Office Financial Agreement: Authorization of Assignment of Insurance Benefits

Lori McAuliffe, M.D., P.A., 405 Pasadena Avenue South, St. Petersburg, FL 33707

Insurance Information

Patient Name: ____

Primary Insurance Name: ______________________________________ Effective Date: ______________

Policy Holder's Name: ______________________________________ Co-Pay Amount: ______________

ID or Policy #: ____ Group #: ____________________

P.O.Box for Claims: ____

The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical insurance status. I certify that my child has health insurance currently in force as detailed above. I assign directly to Lori McAuliffe, M.D., P.A. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic. I, the undersigned, agree to be financially responsible:

____ _______________

Signature of Parent Date

****Please initial after each statement that you understand and agree to abide by our policies****

I understand payment for all medical care is due at the time of service. In case of divorced parents, responsibility and payment shall be that of the guardian bringing the child in for treatment. I understand that it is my responsibility to pay any deductible, co-insurance, or any other balance not paid by my insurance company. I understand that if my account is not paid in full by my insurance within 60 days of the date of service, that I am responsible for payment in full. I understand a late fee of $30 per month will be applied to balances once they become 60 days overdue. **Initial:** ______

If your insurance requires a co-pay, there is a $40 billing fee when the co-pay is not paid on the date of service. Your insurance requires you to pay your co-pay at every visit and we incur an expense in billing for these small balances. Therefore, we find it necessary to charge this fee. There is a $50 returned check fee for any checks returned for insufficient funds**.** **Initial:** ______

Dr. McAuliffe requires 24-hour advance notice for all cancellations or missed appointments. Failure to notify our office will result in a $50 fee for missed sick visits and $100 fee for missed well visits. Due to staffing costs, there is a $200 fee for missed double-well visits and a $300 charge for missed triple visits of any kind with NO EXCEPTIONS. Emergencies will be considered on a case-by-case basis for a waiver of this fee**.** Walk-ins, without a call ahead, will incur a $35 charge. Any applicable fees will be charged to your credit card. **Initial:** ______

If your child receives a vaccine during his/her visit, and we are later notified that no insurance was effective for that date of service or that your plan doesn't cover vaccines, you will be responsible for the full cost of the vaccine. The Vaccines For Children Program provides vaccines free of charge for un-insured patients but we must be made aware that they are un-insured at the time of the visit to be eligible. **Initial:** ______

Dr. Lori offers families the option of paying an annual administration fee of $100 to cover the costs of after-hours phone calls, prescription refills, and form completion outside of a visit. For families who choose not to contribute, there will be a $35 fee for after-hours calls, a $35 fee for completion of school/FMLA forms without a visit, and a $35 fee to refill prescriptions for any patient who has not been seen for the condition requiring an Rx in the past 3 months. **Initial:** ______

Authorization To Treat

I hereby request and give my permission and full consent for LORI McAULIFFE MD,PA (the physicians and the staff) to provide such medical examination and treatment as they deem best for my child's physical and/or mental welfare. I will notify the physician's office of any change in this information or permission. **If patient is over 18,** please indicate your permission to discuss *your bill* with your parent(s)? If no is selected, then PATIENT is responsible for all bills/fees. **Circle one: Yes No**

****Signature of Parent/Patient over 18:** ______________________________