

GM Account# _____

Jacksonville Pediatric & Adult Congenital Cardiology

A Division of Florida Pediatric Associates, LLC

PATIENT INFORMATION

Patient Name: _____ DOB: ___/___/___ SS#: ___-___-___ Sex: Male ___ Female ___

Address: _____ City: _____ State: _____ Zip: _____ Phone#: (____) _____

Race: African American/Black American Indian or Alaska Native Asian Native Hawaiian or Other Pacific Islander White

Ethnicity: Hispanic Non-Hispanic Declined

Other family members treated here: _____

Primary Care Physician: _____ Phone#: (____) _____ - _____

Pharmacy : _____ Pharmacy Phone: (____) _____ - _____

Email: _____

Preferred Method of contact: Email Mail Home Phone Cell Phone Text Message

Whom may we thank for referring you: _____

PARENT(S) / LEGAL GUARDIAN INFORMATION

Who has legal Custody of the Patient: ()Parents ()Mother Only () Father Only () *Foster Parent () Grandparent () *HRS/Other

* APPROPRIATE PAPERWORK MUST BE PRESENTED AT TIME OF VISIT

Mother/Guardian's name: _____ DOB: ___/___/___ SS#: ___-___-___

Address: Check here if same as above

_____ City: _____ State: _____ Zip: _____

Home #: (____) _____ - _____ Cell#: (____) _____ - _____ Work#: (____) _____ - _____

Check this box if we may use this cell # for text and/or robocall appointment reminders

Occupation: _____ Employer _____ Employer Address _____

Father/Guardian's name: _____ DOB: ___/___/___ SS#: ___-___-___

Address: Check here if same as above

_____ City: _____ State: _____ Zip: _____

Occupation: _____ Employer _____ Employer Address _____

Home #: (____) _____ - _____ Cell#: (____) _____ - _____ Work#: (____) _____ - _____

Check this box if we may use this cell # for text and/or robocall appointment reminders

Preferred Language: _____ Preferred method of contact: Email Phone Cell Phone Text

EMERGENCY CONTACTS

#1. Name: _____ Relationship: _____ Phone#: (____) _____ - _____

#2. Name: _____ Relationship: _____ Phone#: (____) _____ - _____

INSURANCE INFORMATION

Primary Insurance Carrier: _____	Policy# _____	Group# _____
Policyholder's Name: _____	Date of Birth _____	
Policyholder's SS#: _____	Relationship to patient: _____	
Claims Address: _____	City: _____	State: _____ Zip: _____
Eligibility Phone# (_____) _____ - _____		
Secondary Insurance Carrier: _____	Policy# _____	Group# _____
Policyholder's Name: _____	Date of Birth _____	
Policyholder's SS#: _____	Relationship to patient: _____	
Claims Address: _____	City: _____	State: _____ Zip: _____
Eligibility Phone# (_____) _____ - _____		

ASSIGNMENT OF BENEFITS/ACKNOWLEDGMENTS

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 to the organization for any charges not covered by health care benefits. 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 received.

By signing this document, I also 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.

Parent/Guardian Signature _____ Date _____

OFFICE POLICY FOR PAYMENT

Payment is expected IN FULL at the time services are rendered by the patient or the person accompanying the minor 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. I understand that I am financially responsible for any balance not covered by my insurance carrier. 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 fee.

I have read and understand the office policy for payment and agree to the terms as stated.

Parent/Guardian Signature _____ Date _____