Ellenton Pediatrics

Cristian Chiritescu, MD, FAAP
Alina Chiritescu, MD, FAAP
Jessica M. Zeller, ARNP, CPNP
Jessica R. Eastman, ARNP, CPNP

8425 US Highway 301 North • Parrish, Florida 34219 • www.EllentonPeds.com
Office 941-723-7877 • Fax 941-723-7844

FINANCIAL POLICY

Your insurance is a contract between you and the insurance company. We are not a party to that contract. Not all services are covered benefits. We must emphasize that as a medical care provider, our relationship is with you, not your insurance company. While the filing of an insurance claim is a courtesy that we may extend to our patients, all charges are your responsibility from the date the services are rendered.

We will be happy to bill your insurance and will accept the assignment, however, any unmet deductible coinsurance and co-pay will be collected at the time service is rendered. Any difference will be included in our monthly statements and payment is expected upon receipt.

If there is an uncertainly regarding insurance coverage for services that we provided, we prefer that you contact your insurance carrier directly for benefits on your plan.

If Ellenton Pediatrics is a participating provider for your insurance company and your policy requires a written referral for any visit to the specialist it is your responsibility to inform us at least 48 hours before your appointment time, otherwise you will be responsible for the insurance denial of services provided by the specialist.

Payment for services is due at the time services are rendered. Any patient responsibility transferred by the your insurance is due immediately after it is determined by your insurance and communicated by us through our monthly statements. For your convenience, we offer the following methods of payment: personal checks in person or by mail and credit cards payments either in person or by telephone.

There will be a fee of $20 charged to the patient's account for missed appointments that were confirmed with the patient's parents or appointments canceled without at least eight hours advanced notice.

FINANCIAL ARRANGEMENTS

We expect payment in full at each appointment. All returned checks are subject to an additional $25 fee. **LATE FEES WILL BE ASSESSED ON ANY OUTSTANDING BALANCES DUE.**

AUTHORIZE AND RELEASE

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such care to third party payers an/or other health practitioners.

I authorize and request my insurance company to pay directly to the physican or physician's group insurance benefits. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on behalf of my dependents. I understand and accept that I am financially responsible for any and all charges incurred for professional services rendered to me. I also understand and accept that I am responsible for any charges incurred should collection proceeding become necessary to enforce that agreement. I have read and understand the above.

Parent's Signature _____ Date _____

PRIVACY POLICY NOTICE AND CONSENT

My signature below represents my understanding and willingness to comply with this policy. I acknowledge I have read and received a copy of the Ellenton Pediatric Privacy Policy brochure.

Parent's Signature _____ Date _____