Maria Rizo M.D.,F.A.A.P.
Kimberly R. Meles, D.O. F.A.A.P

FINANCIAL POLICY ACKNOWLEDGEMENT

Thank you for choosing us as your Healthcare Provider. We are committed to providing you with the highest quality of healthcare. The following is a statement of our **FINANCIAL POLICY** which we require you to **read and sign** prior to us providing you with any medical service.

ALL PAYMENTS ARE DUE AT THE TIME OF SERVICE. If we are providers for your insurance, we will bill your insurance and collect only the patient responsibility amount at the time of service. IT IS YOUR **RESPONSIBILITY TO INFORM US OF ANY CHANGES WITH YOUR INSURANCE**. Many insurance plans have "timely filing deadlines". If we are not provided with accurate information at the time of service, you may be responsible for payment in full for all services rendered. _____ (initial)

On occasion, your insurance company needs **additional information from you** in order to process your claim. You must respond to your insurance company promptly. We will send you a statement with a note asking you to contact your insurance company. If your claim is not paid by your insurance company by the time we send the next statement, **you will be responsible for payment in full at that time**. If when your insurance company pays the claim, we will credit your account. _____ (initial) Maria L. Rizo, MD has preferred provider contracts with several major insurances companies. Please contact your insurance company to determine if our practice has a contact with **YOUR** insurance company. Any financial portion that is the "member's responsibility" such as co-pay, deductible or a non-covered percentage will be collected **AT THE TIME OF SERVICE** _____(initial) If you believe your deductible has been met, please bring an "Explanation of Benefits" form which you receive from your insurance company as proof. We will then collect only your co-pay. We will estimate co-payments to the best of our ability. Since the co-pays are estimates only, we will bill you or credit you for your balance. If, for any reason, it is not collected at the time of service, a finance charge will be added to your outstanding balance for each statement that is mailed. _____ (initial). **Remember your insurance coverage is a contract between you and your insurance company. Maria L. Rizo is NOT RESPONSIBLE FOR SERVICES DENIED BY YOUR INSURANCE COMPANY**_____ (initial)

PAYMENTS: We accept cash and personal checks. Any outstanding balances **are due within 30 days** of the statement. **The second and each subsequent shall accrue interest at the rate of 10.5% per calendar month**. If you experience circumstances beyond your control, please call our office and **we will be happy to make payments arrangements**. All balances reaching 90 days past due may be sent to a collection agency. **Should your account be sent to a collection agency, you will be financially responsible for all collection fees and legal fees that our office incurs through the process utilized to collect the delinquent balance** _____ (initial)

RETURNED CHECKS: Checks returned to us by the bank will be assessed a **$30.00 returned check fee**, in addition to the original amount of the check. You will have **15 days** to clear up the outstanding check. If you do not pay the check plus the return fee in the specified time, the check

Maria Rizo M.D.,F.A.A.P.
Kimberly R. Meles, D.O. F.A.A.P

will be sent to a collection agency. In addition, we will only accept cash for any future visits._____ (initial)

MISSED APPOINTMENTS: We understand there will be times when a scheduled appointment cannot be kept. If you need to cancel or reschedule an appointment, we request that you notify our office 24 hours in advance. If your appointment is made for "the same day" and you find yourself unable to keep it, please call to cancel with a minimum of one hour notice in order for another patient to be scheduled. **IF YOU DO NOT CANCEL BY THE DEADLINE, A $25.00 MISSED APPOINTMENT FEE WILL BE ADDED TO YOUR ACCOUNT. THIS FEE IS NOT PAYABLE BY YOUR INSURANCE COMPANY AND WILL BE YOUR RESPONSIBILITY TO PAY AT OR BEFORE YOUR NEXT APPOINTMENT _____ (initial)**

COMPLETING INSURANCE FORMS, REQUESTING LETTERS FROM DR RIZO, ETC. Requires office staff time and time away from patient care for Dr. Rizo. We may require pre-payment for completing forms or requesting letters, the charge is determined by the length and complexity of the form or letter (minimum of $10.00) _____ (initial)

DIVORCED PARENTS OF MINOR PATIENTS-DIVORCE DECREE: We are not party to your divorce decree. The responsibility for payment and the presentation of active insurance cards at the time of service is the responsibility of the accompanying adult._____ (initial)

As your designate, our practice may accept your child for a doctor consult, with a friend or family member that is involved in your child's care or who assist you in taking care of your child **ONLY** by written authorization from the parent/legal guardian. The person (chaperone) designate by you should be eighteen years old or older. Our practice will not accept patients seventeen years old or younger for a doctor consult without a parent /legal guardian or designate chaperone._____ (initial)

I authorize medical care and accept the financial responsibility. I am responsible for all fees and will assure the charges are paid in a reasonable time.

I authorize the release of any medical or other information that may be necessary for either medical care or in processing applications for financial benefit.

I have read and fully understand the financial policies of Maria L Rizo, MD and agree to the terms. I also understand that the terms of these financial policies may be amended by the Practice at any time without prior notification.

ignature of Legal Guardian **Date**

Maria Rizo M.D.,F.A.A.P.
Kimberly R. Meles, D.O. F.A.A.P

_____ _____

PRIVACY STATEMENT ACKNOWLEDGEMENT

I acknowledge Maria L. Rizo, MD, has provided its Notice of Privacy Practices, either posted or an individual copy, which provides a detailed description of the uses and disclosures allowed regarding my child's protected health information. If I desire, a copy of the Notice of Privacy Practices is available for me to keep. If revisions are made, I understand that is my responsibility to request a revised copy. (Posted copy)

Signature of Legal Guardian **Date**

_____ _____

ACKNOWLEDGEMENT OF "ABUSE FREE ZONE"

At ABC Pediatrics, we appreciate and respect our staff. It is our belief that our staff should have a work environment free from verbal and physical abuse. We expect each one of you to treat each one of our staff members as you would like to be treated. Outburst against our staff will not be tolerated and may result in your discharge from the practice.

My signature below indicates that I agree to abide by the above "abuse free environment" policy.

Signature of Legal Guardian **Date**

_____ _____

FOR PATIENTS NEW TO OUR PRACTICE

How did you find out about our office? Friend/Relative_____

Referred by St Lucie Medical Center_____

Referred by Lawnwood Hospital_____

Google_____Website_____

Other_____

1100 SW St. Lucie West Blvd, Port St. Lucie, Florida 34986
Phone: (772) 344-1775 Fax: (772) 344-1786

Maria Rizo M.D.,F.A.A.P.
Kimberly R. Meles, D.O. F.A.A.P

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

PATIENT NAME: _____

DAY OF BIRTH: _____

LIST OF PERSONS (OTHER THAN PARENTS) WHO HAVE PERMISSION TO BRING PATIENT TO APPOINTMENTS:

NAME: _____ RELATIONSHIP_____

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

SIGNATURE OF PARENT (GUARDIAN): _____

DATE: _____

*********THIS DOCUMENT IS GOOD FOR 6 MONTHS OR UNTIL INFORMATION IS UPDATED BY THE PARENTS, ONLY THE PARENTS OR LEGAL GUARDIAN CAN UPDATE OR CHANGE THE INFORMATION AT ANY TIME)**************

1100 SW St. Lucie West Blvd, Port St. Lucie, Florida 34986
Phone: (772) 344-1775 Fax: (772) 344-1786