

WEST ORLANDO PEDIATRICS

Kevin O'Brien, D.O.

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407-290-WELL (9355)



WELCOME TO OUR OFFICE

Today's Date: _____

Child's Legal Name: _____

Sex: M F Birth Date: _____

Address: _____

Email Address: _____

Home Phone Number: _____

Appointment/Message Reminder Phone Number: _____

Father (or Guardian) Name: _____

Birth Date: _____ SS#: _____

Cell Phone #: _____

Address: _____

Employer: _____

Occupation: _____

Mother (or Guardian) Name: _____

Birth Date: _____ SS#: _____

Cell Phone #: _____

Address: _____

Employer: _____

Occupation: _____

Insurance Company Name & Address:

Insurance Phone Number: _____

Policy Holder Name: _____

Policy #: _____

Group #: _____

Lab: _____

Person Financially Responsible for account: _____

****Payment is due by whoever brings child in***

Names and Ages of Siblings: _____

Preferred Pharmacy: _____

If Parents are Divorced, who has legal Custody?

Who, if anyone, other than the responsible party has permission to be involved in your child's medical treatment including bringing them to appointments?

Name Relationship

****PAYMENT FOR SERVICES IS EXPECTED AT THE TIME OF CHILD'S VISIT****

- _____ 1. I undersigned hereby assign, transfer and set over to West Orlando Pediatrics all my rights, title and interest in and to medical and/or surgical benefit payments to which I am entitled resulting from the medical and/or surgical services performed for my child by West Orlando Pediatrics and I direct my insurance company to pay any and all entitlements directly to West Orlando Pediatrics. Depending upon your insurance plan, you may receive a separate bill for laboratory services from an area lab in addition to our services.
- _____ 2. I authorize West Orlando Pediatrics to render medical care to my child. Charges shown by statements are agreed to be correct and reasonable unless protested in writing within thirty (30) days of billing date. In the event that my account becomes delinquent and must be turned over to collection agency or attorney, I agree to pay any and all cost of collection including attorney fees.
- _____ 3. I have received a copy of West Orlando Pediatrics office policies.
- _____ 4. I have read the "Notice Of Health Information Practices" detailing how my information may be used and disclosed as permitted under federal and state law. I further understand that I have the right to request restrictions as to how my health information may be used or disclosed and that the organization is not required to agree to these restrictions. I also may request a copy to keep at any point of time.

Parent or Legal Guardian Signature

Date

WEST ORLANDO PEDIATRICS



Permission to Treat

I (We) _____ authorize West Orlando Pediatrics and its
Print name(s) of legal guardian(s)
personnel to deliver medical services to my child(ren), listed below.

(Please print)

Name: _____

Date of Birth: _____

Name: _____

Date of Birth: _____

Name: _____

Date of Birth: _____

Name: _____

Date of Birth: _____

I (We) authorize the following people to bring my child(ren) in for treatment, and/or to contact
in case of an emergency:

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Signature(s) of Legal Guardian(s)

Date

Relationship to patient

Primary phone number

Who can we thank for referring you to our practice _____



West Orlando Pediatrics

OFFICE POLICIES:

Kevin O'Brien, DO
Chelsea Barbieri, APRN

1. Charges/Payments at the Time of Service

All co-pays, deductibles, and balances are due at time of service. Our office requires payment in full when services are rendered, unless arrangements have been made with our billing department. We do not extend credit to our patients; therefore, if payment arrangements must be made, they must be suitable to both parties.

It is the patient/guarantor's responsibility to know their insurance benefits. Please check with your insurance carrier to see what your benefits, co-payments and deductibles are.

The accompanying parent or other adult who brings in the child is responsible for full payment and providing current insurance information. Accounts must be paid in full in order to schedule a Well Visit.

We accept cash, check, MasterCard, Visa, Discover, Amex and Apple Pay

In case of Divorce or Separation, the parent and/or legal guardian who brings the child in for medical services will be required to pay the bill. We do not bill third parties regardless of what the decree or custody documents indicate. Please make appropriate arrangements prior to the office visit.

Self-Pay Patients

Payment needs to occur prior to the beginning of the visit. If there are any In House tests ,procedures or vaccines done in office, there will be an additional cost that is patient responsibility. We would collect that fee prior to leaving the office visit.

2. Insurance Claims

We must have a current copy of your insurance card on file. If we are unable to verify your insurance benefits, you will be required to pay self-pay at the time of service.

We will submit a claim for services to your insurance company for reimbursement. You must assign benefits to our office if you do not pay for your visit in full. After thirty (30) days, if the insurance company has not paid your claim, the balance becomes your responsibility. We reserve the right to limited insurance submissions/inquiries.

It is imperative that accurate PRIMARY insurance information is given in order to properly submit claims for payment. If insurance information provided is found to be inaccurate, the guarantor will be responsible in full for any charges incurred. Our billing office will not be responsible for any retractions from insurance companies and/or additional inquiries due to non-payment.

Newborns must be added to your policy as soon as possible

Most insurance companies require they be added within thirty (30) days after the baby is born.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. It is your responsibility to see that any charges submitted to the insurance carrier are paid in a timely manner. We will do our best to work with your insurance carrier, but there may be times when you must get involved and we may ask you to contact them if there is a problem getting a bill paid.

3. Billing Inquiries

Please have your question and all necessary information available for prompt attention/resolution. Should we find the billing error is on our part, we will correct the problem. If, however, the problem is with the insured/insurance, (i.e. insurance termed), more information needed from the subscriber, coordination of benefits, it will be the subscriber's responsibility to correct the problem with their insurance company. At this time, all balances are due in full. When the insurance company issues benefits, you will receive reimbursement.

4. Monthly Statement

Statements are sent out each month. This statement will include individual and/or family balance with account numbers. When you receive your statement, it means the balance is now your responsibility. Our statements are clear and concise.

Payment is expected upon receipt of the statements. Please notify the office if you have questions as soon as possible so that any balances due can be taken care of in a timely manner. Please note that our office accepts payments by phone or online at www.westorlandopediatrics.com

5. Delinquent Accounts

An account becomes delinquent if payment is not made at time of service in reference to co-pays and balances. We will send a statement within the first thirty (30) days for payment in full. If another statement is sent, this account is now considered for collection proceedings. Our billing department does its best to try and collect unpaid balances before collection proceedings. We extend courtesy calls, set up payment plans, work with insurance companies, etc.; this requires a lot of time and effort. However, when this becomes uncollectible, we have no alternative than to turn unpaid accounts over to our collection agency; a percentage fee will be assessed based on the unpaid balance. Please refer all inquiries to our agency; **FFCC Florida at 1-800-486-5500**. At this point, the account will be subject to discharge from our practice.

When a patient is discharged from our practice, we will provide care for thirty (30) days. If your account is resolved, patient care may be continued upon the discretion of the administrative/billing department. At that time, visits will be due at time of service and any reimbursements from insurance companies will remain on account/or refunded.

6. Returned Checks

A \$35.00 fee will be charged for all returned checks. We will not redeposit returned checks. The entire amount of check and fee must be paid in full within ten (10) days of notice. If more than one return check occurs, you will be asked to pay by cash or credit card only- no checks accepted.

7. Referrals

If your insurance company requires a referral form to a specialist, we ask that you make an appointment with the specialist then call our office for a referral at least 48 hours in advance. It is your responsibility to know if you need a referral and the time requirements.

8. Missed Appointments

To ensure we are able to meet the needs of our patients and to assure we have adequate openings for children needing appointments, we require 24-hours advance notice to cancel a scheduled appointment. No shows and short notice (less than 24 hours) cancellations are subject to a \$25.00 fee per missed appointment. This includes same day appointments that are canceled or rescheduled. Please do not cancel appointments through our afterhours service, you must call the office during normal business hours.

9. Early Patients

We appreciate your diligence in arriving to your appointment early. Please understand that traditionally patients are seen in the order of their scheduled appointment times, rather than on their time of arrival. In the event that you are more than 20 minutes early for your appointment, we will try to accommodate you as soon as possible. In the spirit of fairness, please be aware, however, that patients who are scheduled before you and arrive on time for their scheduled appointment will be seen first, even if they arrive after you. In the event that multiple providers are working, patients will be taken back according to their provider's schedule. Thus, if patients are seeing different providers, it may appear that later arriving patients are being taken back ahead of earlier arrivers.

10. Late Patients

We are trying very hard to keep our schedule running efficiently and on time. If you arrive 15 minutes late or more to your appointment you will likely be asked to reschedule unless the physician's schedule can still accommodate you. Priority will be given to the patients who arrive on time and you may have to be worked in between them. This may mean you will have a considerable wait. If this is not convenient for you, you may choose to reschedule. If you arrive late or early it creates a bottle neck effect which causes the entire daily schedule to fall behind. This is an inconvenience to everyone, so please try to be on time for your scheduled appointment.

11. Laboratory Services

Some lab services are sent out of our office. You will receive a separate bill for these services from the laboratory which is appropriate for your insurance company. It is your responsibility to know which laboratory your insurance company participates with. Our office cannot be held responsible. Any tests/labs done in the office may be subject to your deductible and/or coinsurance; you are responsible for those charges.

12. Record Transfer

In order to cover the cost of time and material there will be a fee of fifty cents (\$0.50) per page plus postage for copying patient charts. Charts will only be mailed once to the requested party, and we cannot be held responsible for the chart copy once it has been mailed. A written request is required for all record transfers. We send records courtesy doctor to doctor. Please refer to our record coordinator for any additional information and/or forms.

13. Appointments

We ask that all patients/parents who have been exposed to or have covid symptoms to wear a mask while in the office to protect our children who are unable to get vaccinated. Masks are available at check in.

All visits require appointments. Please call before coming into the office. By calling our office first, we can see all of our patients in a timely fashion based on their medical needs. We can almost always see sick visits on a same day basis. Please call as early in the day as possible so we may schedule your child as time permits.

If more than one of your children needs to be seen, please schedule appointments for each of them. This assures that the proper time is allotted for each child for a complete evaluation.

Combined Visits

If you are scheduled for a well-child exam, and other health concerns are brought up that would typically require a sick visit, your insurance may consider these two separate visits and bill your copay and other charges accordingly. You will be responsible for these payments.

***Well Child Appointments:** Accounts must be paid in full in order to schedule a Well Visit. Well Visits (physicals) are scheduled in advance according to the doctor's availability. Calling weeks in advance for your appointments will help to ensure your choice of day and time. **After the age of two**, most insurance plans require **365 days** between well visits.

If you book a well visit less than **365 days** apart it is your responsibility to contact your insurance company to verify that it will be covered under their policy terms. If it is not covered and you have been seen, you will be responsible for that visit fee.

All patients in the practice are required to receive the appropriately timed vaccines recommended by the CDC and AAP or if desired the WOPEDS extended schedule.

14. Miscellaneous Services: Forms. Letters. etc.

FMLA (Family Medical Leave of Absence) or any kind of disability forms will be a flat fee of \$15.00 to be completed. Please allow five (5) business days for completion of forms.

FORMS: From time to time, you may have forms that need to be completed by your physician (physical forms, immunization records, medical clearances, etc.). We ask that you provide us with 24 hours to complete the forms.

PRESCRIPTIONS: Please allow up to **48 business hours** for prescription refills to be processed. Refills on ADHD medications will be provided for patients who have been seen within the last three months for their ADHD evaluation or follow-up.

After-Hours Care:

For urgent medical needs that can't wait until regular business hours, please call the office at 407-290-9355. Dr. O'Brien is available to provide guidance, assess the situation, and determine the appropriate course of action. This may include providing further instructions, prescribing medication, or recommending a visit to the emergency room or urgent care. Some calls may be deemed a telehealth service if they involve a formal medical assessment and you may be required to pay a copay/deductible per your insurance. In the event of a severe emergency, go directly to the nearest emergency room or call 9-1-1 immediately.