Tel: 407- 422 -2255
Fax: 407- 839 -4659

South Orlando Pediatrics, PLLC

Caring and loving children!

100 West Gore Street,
Suite 305,
Orlando, 32806

Financial Policy

I have read the financial policy for the office and understand that I am ultimately responsible for all charges to my account. It is my financial responsability to remit payment for any changes not covered by my insurance plan including, but not limited to co-insurance, co-payments and deductibles. I understand that co-payment for the office visit are due at the time of the service. I understand that patient balances are due within 30 days of notification.

I understand that once my account is put into collections, I am subject to be discharged and held responsible for any additional charges to collect any and all unpaid balances, included but not limited to collection agency fees, attorneys and interest charge by the practice.

Name of Patient . . . . . .

Name of Insurance . . . . . .

Policy ID . . . . . .

Policy Group . . . . . .

Responsible Party Name . . . . . .

Responsible DOB and SS#. . . . . .