

**CLEARWATER OFFICE**

1230 S. Myrtle Avenue  
Suite 205  
Clearwater, FL 33756  
Phone: (727) 447-6458  
Fax: (727) 461-5211

Pediatric Offices of  
DR. GREG SAVEL DR. KAREN KELLY  
DR. KATHRYN BOREMAN  
DR. KIMBERLY ODOM  
www.savelkellymds.com

**OLDSMAR OFFICE**

250 Pine Avenue N.  
Suite B  
Oldsmar, FL 34677  
Phone: (727) 447-6458  
Fax: (727) 461-5211

**PATIENT INFORMATION**

*Please Complete Both Front and Back of Form*

DATE \_\_\_\_\_

CHART # \_\_\_\_\_

How did you hear about our practice? \_\_\_\_\_

CHILD'S FULL NAME _____ First Middle Last	Date of Birth _____	Sex _____
Allergies? _____	Race _____	
CHILD'S FULL NAME _____ First Middle Last	Date of Birth _____	Sex _____
Allergies? _____	Race _____	
CHILD'S FULL NAME _____ First Middle Last	Date of Birth _____	Sex _____
Allergies? _____	Race _____	
CHILD'S FULL NAME _____ First Middle Last	Date of Birth _____	Sex _____
Allergies? _____	Race _____	

**MOTHER / GUARDIAN:**

Name \_\_\_\_\_  
First MI Last  
Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ SS# \_\_\_\_/\_\_\_\_/\_\_\_\_  
Occupation \_\_\_\_\_  
Employer \_\_\_\_\_  
Work / Daytime Phone (\_\_\_\_) \_\_\_\_\_ Ext. \_\_\_\_\_  
Home Address \_\_\_\_\_  
Apt # \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_  
Mailing Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_  
Home Phone (\_\_\_\_) \_\_\_\_\_  
Cell Phone (\_\_\_\_) \_\_\_\_\_

**FATHER / GUARDIAN:**

Name \_\_\_\_\_  
First MI Last  
Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ SS# \_\_\_\_/\_\_\_\_/\_\_\_\_  
Occupation \_\_\_\_\_  
Employer \_\_\_\_\_  
Work / Daytime Phone (\_\_\_\_) \_\_\_\_\_ Ext. \_\_\_\_\_  
Home Address \_\_\_\_\_  
Apt # \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_  
Mailing Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_  
Home Phone (\_\_\_\_) \_\_\_\_\_  
Cell Phone (\_\_\_\_) \_\_\_\_\_

If there are any family members or others who may be notified in an emergency or bring your child/children in for treatment and receive protected healthcare information (including HIV testing, drug and alcohol testing and psychotherapy treatment), please list below.

Name _____	Phone # _____	Relationship _____
Name _____	Phone # _____	Relationship _____
Name _____	Phone # _____	Relationship _____
Name _____	Phone # _____	Relationship _____

PLEASE READ AND SIGN REVERSE SIDE

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**INSURANCE INFORMATION and FINANCIAL POLICY**

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**POLICY HOLDER'S INFORMATION** Information MUST Be Completed To File Claims

Name \_\_\_\_\_ Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ SS# \_\_\_\_/\_\_\_\_/\_\_\_\_  
First MI Last  
Occupation \_\_\_\_\_ Employer \_\_\_\_\_  
Employer's Address \_\_\_\_\_ City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_

**ASSIGNMENT of INSURANCE**

- I am self pay.
- I am self pay and file my own insurance.
- I authorize the release of medical information or other information necessary to process any claims for my dependents for payment.
- I authorize payment of benefits directly to the physician who accepts assignment and provided the services.
- I reside out of town and understand I will need to file my own claim and be reimbursed for payment.

**FINANCIAL POLICY**

1. **ALL FEES ARE DUE AT THE TIME SERVICE IS RENDERED.** IF NOT PAID, THERE WILL BE A \$10.00 BILLING FEE ADDED TO ACCOUNT.
2. DUE TO CONTRACTUAL OBLIGATIONS, **NO FEES, COPAYS OR DEDUCTIBLES WILL BE WRITTEN OFF OR FORGIVEN.**
3. VALID **INSURANCE CARDS MUST BE PRESENTED AT EACH OFFICE VISIT.** IF YOU DO NOT HAVE A VALID INSURANCE CARD, WE WILL NOT FILE ANY CLAIMS FOR THE VISIT AND ALL CHARGES FOR THAT VISIT WILL BE THE RESPONSIBILITY OF THE PATIENT OR THEIR PARENT OR GUARDIAN.
4. PLEASE UNDERSTAND THAT EACH PATIENT, OR THEIR PARENT OR GUARDIAN, IS RESPONSIBLE FOR PAYMENT OF FEES. IF WE PARTICIPATE IN AN INSURANCE PLAN, WE WILL FILE THE CLAIM FOR YOU. IF WE ARE NOT PROVIDERS, PAYMENT IN FULL IS DUE AT TIME OF SERVICE AND SUBMISSION OF CLAIM IS THE GUARANTOR'S RESPONSIBILITY.
5. ALL **OUT OF TOWN PATIENTS** ARE CONSIDERED **SELF PAY.**
6. IN THE CASE OF DIVORCED OR SEPARATED PARENTS, **RESPONSIBILITY SHALL BE THAT OF THE PARENT OR GUARDIAN BRINGING THE CHILD IN FOR TREATMENT.**
7. DUE TO FEDERAL PRIVACY REGULATIONS, THE ADULT WHO BRINGS A CHILD IN FOR TREATMENT MAY BE ASKED TO PRESENT PROOF OF IDENTIFICATION AT EACH VISIT (DRIVER'S LICENSE, ETC.).
8. THERE WILL BE A **SERVICE CHARGE ON ALL RETURNED CHECKS.** NORMALLY, THE BANK PRESENTS AN NSF CHECK A SECOND TIME AUTOMATICALLY. EACH REJECTION WILL RESULT IN AN ADDITIONAL SERVICE CHARGE TO YOUR ACCOUNT. AFTER AN NSF CHECK, WE MAY REQUIRE CASH OR MONEY ORDERS FOR PAYMENT.

THIS IS THE PHILOSOPHY OF THE OFFICE. HOWEVER, THE OFFICE MANAGEMENT RESERVES THE RIGHT TO AMEND THIS POLICY AT ANY TIME.

I HAVE READ THE ABOVE STATEMENTS AND AGREE TO THE OFFICE POLICY.

\_\_\_\_\_  
GUARANTOR SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
GUARANTOR SIGNATURE

\_\_\_\_\_  
DATE