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 (_____)_________________________

Email ________________________________

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 (_____)_________________________

Email ________________________________

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___________

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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.

SIGNATURE______________________________________ DATE____________________

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, co-pays or deductibles will be written off or forgiven.
3. Valid insurance cards must be presented at each office visit.
4. It is your responsibility to inform us of any changes to your insurance policy.
5. Not all services are a covered benefit with all insurance plans.
6. It is your responsibility to be aware of what service(s) is being provided to you and if it is a covered medical benefit under your insurance policy.
7. You are responsible for any non-covered charges not payable by your insurance policy.
8. Although filing your insurance claims is a courtesy extended to you, all charges are always your responsibility from the date services are rendered.
9. 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 the time of service and submission of claim is the guarantor's responsibility.
10. All out of town patients are considered self-pay.
11. In the case of divorced or separated parents, responsibility shall be that of the parent or guardian bringing the child in for treatment.
12. Due to federal privacy regulations, the adult who brings the child in for treatment may be asked to present proof of identification at each visit (driver's license, etc.).
13. 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 require cash, credit card 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.
We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we urge you to contact us promptly for assistance in the management of your account. If you have any questions about the above information, please do not hesitate to ask us. We are here to help you.

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

______________________ ____________ ______________________ ____________
GUARANTOR SIGNATURE DATE GUARANTOR SIGNATURE DATE