Jeth V. Salomon, M.D.
General Pediatrics
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Suite 1
St. Petersburg, FL 33710
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AUTHORIZATION FOR RELEASE OF RECORDS

Do not put your personal information or Dr. Salomon's information on this form.

____
(Phyician/Practice/Hospital to provide Salomon Pediatrics with records)

____
(Office/Facility Mailing Address)

____________________________ ____________________________
(Phone Number) (Fax Number)

The recipient of this release is hearby authorized to furnish Jeth V. Salomon (Physician of Salomon Pediatrics) with a copy of the medical records compliled during the hospitalization and/or outpatient care of:

____
Patient Name and Date of Birth

We are requesting up to the **last three years of medical records**, **Growth Chart**, **Immunization Records**, and **any other necessary documents** for the patient stated above.

Please do not fax more than 20 pages, or your fax may not be received. If the patient's records are greater than 20 pages, please call to confirm *before* sending.

Parent/Guardian Signature: ______________________________________
Relationship to Patient: _______________________ Date: ____/____/______

Child's Information:

Name: ________________________________ Date of Birth: ___/___/______ Sex: M/F
Current Age: _________ Grade:______ School:________________________________
Preferred Name: ______________ Siblings' Names: ____________________________
Primary Phone Number: (____)__________ ☐ Check if you can receive texts at this number
Primary Email: ____

Parent/Guardian Information:

If nothing has changed since last time, check the box and skip this section ☐

Parent/Guardian 1:
Name: ________________________________ Relation to Child: _________________
Date of Birth: ___/___/______ Sex: M/F ☐ Lives with Child ☐ Primary Contact
Address: __________________________________ City: __________ Zip: __________
Phone: (____)__________ Email: ______________________________________
Marital Status: __________________ Occupation: ____________________________

Parent/Guardian 2:
Name: ________________________________ Relation to Child: _________________
Date of Birth: ___/___/______ Sex: M/F ☐ Lives with Child ☐ Primary Contact
Address: __________________________________ City: __________ Zip: __________
Phone: (____)__________ Email: ______________________________________
Marital Status: __________________ Occupation: ____________________________

Responsible for Payment (Guarantor): ☐ Parent/Guardian 1 ☐ Parent/Guardian 2
Guarantor Social Security Number: _____-_____-_______

Insurance Information:

If nothing has changed since last time, check the box and skip this section ☐

Primary Insurance:
Insurance Name: _________________ Insurance ID: ___________________________
Group Number: ______________ Effective Date: ___/___/______ Co-pay: $________
Subscriber (Owner of Plan): ☐ Parent/Guardian 1 ☐ Parent/Guardian 2 ☐ Child/Self
Plan Description (If Applicable): _____________________________________

Secondary Insurance (If Applicable):
Insurance Name: _________________ Insurance ID: ___________________________
Group Number: ______________ Effective Date: ___/___/______ Co-pay: $________
Subscriber (Owner of Plan): ☐ Parent/Guardian 1 ☐ Parent/Guardian 2 ☐ Child/Self
Plan Description (If Applicable): _____________________________________

Please Sign and Complete Section Below

Signature: ____ Date: ___/___/______
Name: ________________________________ Relation to Child: _________________

By signing above, you affirm all the information is true and correct, and agree to Salomon Pediatrics's terms and policies.

Financial Responsibility Agreement

I, the undersigned patient or legal guardian, hereby acknowledge and accept financial responsibility for all charges associated with the medical services provided to me or the patient listed below by Salomon Pediatrics, and its physician Dr. Jeth V. Salomon, hereinafter referred to as "the Provider." This agreement outlines the financial responsibilities, billing procedures, and insurance matters related to the medical services.

Insurance Information: I understand that it is my responsibility to provide accurate and up-to-date information about my insurance to the Provider. This includes the insurance name, policy number, group number, and any other necessary information. I am responsible for understanding my coverage, including co-payments, deductibles, and any other out-of-pocket expenses.

Payment Obligation: I understand that I am responsible for all charges incurred for the medical services provided, whether insurance covers the costs or not. This includes, but is not limited to, co-payments, deductibles, non-covered services, and any other charges beyond the limits of my insurance policy. All payments should be made in a reasonable timeframe using any major credit card, debit card, cash, check made out to the Provider, or other accepted payment methods.

Billing Procedures: I acknowledge that I will receive statements from the Provider outlining the services provided and the associated charges. These statements will be given in person, sent by mail, or emailed, whichever is more convenient for the Provider. It is my responsibility to review these statements for accuracy and immediately notify the Provider of any discrepancies.

Payment Due Date: I understand that payment for all outstanding balances is due within 30 days of receiving a statement. Failure to make timely payments may result in additional charges, including but not limited to, late fees, interest charges, collections fees, and court costs.

Collections and Court Fees: If my account becomes past due and requires the involvement of a collection's agency or legal action, I agree to pay all associated fees and costs, including but not limited to, collections fees, court costs, and attorney's fees. I understand that accounts that are sent to a collection's agency will incur a fee equal to twenty-four (24) percent of the total amount owed.

Financial Assistance: The Provider may offer financial assistance or payment plan options for patients unable to pay their entire balance immediately. These options are available to me at the Provider's discretion and only as long as I maintain consistent contact with the Provider. If I need assistance, I should contact the Office to request such arrangements.

REQUIRED

Name of Patient (Please write legibly): ______________________________

Name of Guarantor (Leave blank if same as patient): ______________________________

Signature of Guarantor: ______________________________ Date: _____/_____/__________

By signing above, you affirm all the information is true and correct, and agree to Salomon Pediatrics's terms and policies.