Welcome To Our Office!

Patient Name: _____Patient Date of Birth: _____
First Middle Last

Home Address: _____
City: _____ State: _____ Zip: _____
Telephone: ( ) _____
Mother's name :_____
Cell number: _____ Work number:_____
Father's name : _____
Cell number:_____ Work number: _____

Responsible Party: _____ Relationship to Patient: _____
Home Address: _____
City: _____ State: _____ Zip: _____
Telephone: ( ) _____ Birthdate: _____
Occupation: _____ SSN:_____
Employer: _____
Work Phone: ( ) _____

In case of emergency, contact: _____ Relationship: _____
Home Phone: ( ) _____ Work Phone: ( ) _____

Who may we thank for this referral? _____

Primary Insurance
Name of Insurance Company:

_____
Policy Holder: _____ Relationship to Patient: _____
Address: _____
City: _____ State: _____ Zip: _____
Insured's Name: _____
Group Number: _____ Policy ID Number: _____

Our office will file insurance for all reimbursable services, to your primary insurance carrier as a courtesy. Patients are required for filing claims to all secondary, tertiary, etc. insurance carriers. Please remember that you are responsible for all deductible, copay, and non-covered service amounts. See our complete financial policy for details.

Initial: _____

Patient Financial Policy Sheet

To reduce confusion and misunderstanding between our patients and practice, we have adopted the following financial policies. If you have any questions regarding these policies, please discuss them with our office manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

Unless other arrangements have been made in advance by either you or your health insurance carrier, full payment is due at the time of service. For your convenience we accept [VISA, MasterCard, AMEX, DISC**]. Please ask about filling out our billing file which facilitates this process.**

WE DO NOT ACCEPT PERSONAL CHECKS.

Your Insurance

- We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized amount at the time of service, which may include one of the following:
    - This office's policy is to collect your copayment when you arrive for your appointment. We will never waive your copay as this violates our contract agreement with your insurance.
    - For patients whose insurance will apply the entire amount of the visit to a contract deductible we strongly urge you to pay a $50 deposit for each visit to minimize the amount owed after the visit. If you have a FSA/HSA/HRA card, you can leave the card on file and we can withdraw the amount owed when your explanation of benefits comes in. As a courtesy we will always contact you before withdrawing an amount due that exceeds $150.00.

- If you have insurance coverage with a plan for which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means that your insurer will send the payment directly to you. Consequently, the charges for your care and treatment are due at the time of the service.

- **In the event that your health plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.**

- Claims are filed on your behalf to your insurance company as a courtesy. We will only file claims to your primary insurance. If we are unable to collect payment from the carrier, you are ultimately responsible for the cost of care. State and federal insurance is always secondary to private/commercial insurance.

- **You must notify the office of all active insurance plans that provide medical coverage. Failure to disclose all insurance information and/or arrange coordination of benefits with your carrier(s) may result in recouped claims from the carrier(s), in which case, you will be responsible for paying the full amount of the visit(s) as an out-of-pocket expense.**

Minor Patients

- For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian with custody for payment.

Office Charges:

Our practice charges for missed appointments, if you can not keep your scheduled appointment please call us 24 hours in advance. Our No Show fee is $25.00 for sick visits and $50.00 for well visits and Afterhours Nurse Triage is $35.00. PATIENTS MAY BE RELEASED AFTER AS FEW AS 1 NO SHOWS. If we cannot check you in within 5 minutes of your appointment time, you may need to reschedule. If your chart is being transferred out to another provider (excluding specialists) there is a $25.00 charge.

Please see the reverse side of this document for other practice charges that cannot be submitted to insurance.

Initial:_____

I have read and understand the financial policy of the practice, and I agree to be bound by its terms. I also understand and agree that the practice may amend such terms from time to time.

_____

Printed Name of the Patient

_____

Signature of Patient or Responsible Party if a Minor Date

The following is a list of charges that may be incurred as a patient of Cedar Park Pediatrics. Some of the charges are opt-in only. None of the charges are covered by insurance and will be billed directly to the patients unless this violates our contract agreement with your insurance carrier.

Opt-In Fees: These are items that won't be billed unless you agree to receive these services.

Ear Piercing	$39 includes studs for both ears
Payment Plan Service Fee	$10 ea plan
After Hours Triage	$25 ea call
Parent Flu Vaccine	$29 ea

Opt-Out Fees: These are items that will be billed as default unless you consent to an alternative.

Records Retrieval*	$25 for hard copy up-to 250 pages, or for a CD up to 500 pages
Records Retrieval*	$50 for hard copy 251+ pages, or for a CD 501+ pages

*You may opt-out by requesting that your records be sent to your new provider. Records being released to anyone but a healthcare provider will be provided for a fee. A valid release form must be received if releasing records to a third party.

Penalty Fees: These are fees that are charged for failure to comply with practice policies.

No Show (Sick)	$25 per child per visit
No Show (WCC)	$50 per child per visit
Invoice Past Due (30 days)	$35 per child per visit

Miscellaneous Admin Fees: This is an additional fee for controlled substance refill prescriptions without an appointment to compensate the physicians for time and documentation requirements.

Controlled Substance Refill	$10 per request.	For multiple children or prescriptions, you may avoid duplicate charges by submitting your requests at the same time.

Telephone Protocol

We offer an after-hours triage service that is provided by a third-party. We are required to offer this service to you 24/7. **However**, this service creates a significant operational cost for the practice and we are surcharged for every call. This is why we MUST charge you a $25 per-call fee. Please note that this third-party does not have access to any of your children's chart information or medical history.
Every-time you select Option 7and/or Option 8 in the phone system you will be transferred to the service and billed $25.
If you would like a call back from a member of our staff please use one of the following options:

Option 1-2: Front Desk-No medical advice
Option 3-5: Medical Staff- please use this option for medical advice
Option 9: Menu tree in Spanish
Option 0: Operator- Ask to be transferred to reach voicemail.

Most insurance companies offer their own service for **Free**. The phone number can be found on the back of your insurance card. If your insurance company does not offer this service, you may call the St David's Children's Hospital Nurse Line at 844-533-5437.

Email Consent

Due to the recent changes to HIPAA we are now able to send protected health information by unencrypted email. By signing below you are consenting to allow us to send sensitive information to you via email such as vaccine records, invoices, etc. The disadvantage to unencrypted email is that it is very much like writing the information on a postcard and mailing--every time it changes hands, the person (or server) can read it.

We will not email medical records to you unless you ask us to. In most cases, the only auto-generated emails will be related to billing, insurance, important updates regarding the practice, requests to update your information, and appointment reminders. We do not send complete charts via email.

Please **Check One** of the following:
□ I consent to unsecure email communications. My email address is:

_____

□ I do not consent to unsecure email communications.

Appointment reminders are offered via Automated Text and Voice Messages.
□ I consent to Automated Text and Voice Messages. Data rates may apply based on your carrier.
Phone number _____
□ I do not consent Automated Text and Voice Messages.
Parent sign to acknowledge the above.

_____

Parent Signature Date