Dripping Springs Pediatrics
Kathleen Stinson, MD, FAAP and Associates
331 Sportsplex Dr., Suite C
Dripping Springs, TX 78610
512-894-3737 512-894-3738 fax

Financial Policy

This is an agreement between DRIPPING SPRINGS PEDIATRICS, a Texas professional association, as creditor, and the Patient/Debtor named on this form. In this agreement, the words "you", "your" and "yours" mean the Patient/Debtor. The word "account" means the account that has been established in your name, to which charges are made and payments credited. The words "we", "us", and "our" refer to DRIPPING SPRINGS PEDIATRICS. By executing this agreement, you are agreeing to pay for all services that are received.

__________(initial) ***Insurance:*** Insurance is a contract between you and your insurance company. As a courtesy to our patients we have enrolled in many insurance companies. In doing this we agree to file your insurance claims and take the contracted rates from your insurance company; however, we do not take responsibility for items that are not covered by your individual plan. **You are responsible for knowing your insurance benefits, and will be billed for those items not covered.** We recommend that you always question the insurance regarding your benefits and **do not assume that everything done in the physician's office is covered**. It is also the patient's responsibility to **make sure that we are considered in-network providers under your individual plan**.

__________(initial) **DRIPPING SPRINGS PEDIATRICS will NOT file any claims for patients without an insurance card.** You can request your insurance company to fax you documentation of insurance coverage that includes all billing information. **You will need to provide and confirm the insurance information each time, as we will not be responsible for any denied claims due to filing deadlines if information was not given at the time of service.** Most of the insurance companies have a 90 to 95 day filing limit for claims. If you do not give us your new insurance information within that filing limit, you are responsible for the charges incurred. If your insurance company requires a referral or pre-authorization, you are responsible for obtaining it.

__________*(initial)* ***Labs:*** We do not bill for any send out laboratory testing. Our current lab is CPL. If you request, we can send your labs to Quest Diagnostics or LabCorp. **If you do not inform us of a specific lab requirement by your insurance, you will be responsible for the laboratory bill through CPL.** If your laboratory designated by your insurance company is anything other than CPL, you will need to find which lab is the closest for you to go have your lab work done there. Failure to do so can result in a heavy expense to you.

__________(initial) ***Hearing and Vision Screens:*** Hearing and Vision Screens are generally not covered by insurance companies. We offer both screenings for a $25 fee.

__________*(initial)* ***Monthly Statement:*** If you have a balance on your account, we will send you a monthly statement. It will only show charges that are owed as of that date. Your statement is expected to be paid in full within 30 days after receipt of the statement date, unless other arrangements have been approved in writing. **If payment is not received within 30 days it is considered past due.** We do reserve the right to dismiss your family from the office if your account cannot be maintained in a fair equitable manner.

__________*(initial)* ***Required Payments:*** Any **co-payments, co-insurance, or deductible amounts required by an insurance company must be paid at the time of service.** Because this is an insurance requirement, we cannot bill you for these. Uninsured patients must pay in full at the time of service unless other arrangements have been made ahead of the appointment.

__________*(initial)* ***Divorce:*** After a divorce or separation, **the parent authorizing treatment for the child will be the parent responsible for those subsequent charges.** It will also be that parent's responsibility to provide us with any insurance information that we may require in order to file any claims. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

__________*(initial)* ***Past Due Accounts:*** If your balance becomes past due, we will take necessary steps to collect this debt. **If we have to refer your account to a collection agency, you agree to pay all of the collection costs which are incurred.** If we have to refer the collection balance to a lawyer, you agree to pay all lawyers' fees which we incur, plus all court costs. In case of suit, you agree the venue shall be in Hays County, Texas.

__________*(initial)* ***Waiver of Confidentiality:*** You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

__________*(initial)* ***Missed Appointment Fee***: If a patient **does not show up on time for an appointment, or does not cancel 24 hours prior to the scheduled appointment time, a $25 fee will be charged**. Patients with three missed appointments will be asked to transfer their records to another doctor.

__________*(initial)* ***After Hours Calls:*** Urgent after hours calls are directed to a message system which can be reached by calling 512-894-3737 and choosing option #2. Your message will be returned by the provider on call. **You will be charged a nominal fee of $15 for each after hours call.**

__________*(initial)* ***After Hours Appointments:*** If your child is seen after hours or on the weekend as a courtesy by one of our providers there is an **additional $35.00 charge in addition to your copay** not covered by insurance to be collected at time of service.

__________*(initial)* ***Returned Checks:*** There is a fee **(currently $30) for any checks returned by the bank.** If we received more than one returned check on an account you will be

required to pay with a credit card, money order or cash. We reserve the right to submit your information to the legal authorities, as this is a crime in the state of Texas.

__________*(initial)* ***Refunds:*** Dripping Springs Pediatrics reserves the right to retain any credits $25 and under to be applied toward future visits. In the event the guarantor of the account requests the refund regardless of amount, it will be refunded in a timely manner. Any amounts over $25 will remain on the account as a credit for up to 120 days. If the credit is not applied in that time period, a refund check will be mailed to the last address of record for the guarantor.

__________*(initial)* ***Transferring of Records:*** You will need to request in writing, and pay a reasonable fee (currently **$25 for the first 35 pages and 0.15 cents per additional page**) to DRIPPING SPRINGS PEDIATRICS, if you want to have copies of your records for your own personal files. If you request a transfer of records to another physician, we will send a complimentary medical summary, growth chart, and shot record by fax. If you require the entire medical record, the above fees will apply. You must authorize us to include all relevant information. A copy of your shot record may be obtained in our office. There is no charge for the first copy but each additional copy, there is a $5 fee assessed each additional time requested. If you are requesting your records be transferred from another doctor to us, you authorize us to receive all relevant information.

__________*(initial)* ***Co-signature:*** If another person signs this or another Financial Policy, that co-signature remains in effect until cancelled in writing. If written cancellation is received, it becomes effective with any subsequent charges. It does not release them from responsibility from any prior charges that were incurred.

__________*(initial)* ***Effective date:*** Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

I hereby state that I have read and understand the Financial Policy given to me by DRIPPING SPRINGS PEDIATRICS.

Patient's Name (please print): ____

Responsible Party (please print): ____

Signature: ____

Co-Signor (please print): ____

Co-signature: ____

Received by: ______________________________ Date: ________________________________

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OFFICE POLICY

- You may be seen in the office by Pediatric Physician or a Nurse Practitioner.
- Co-payment is due at the time of service unless prior arrangements are made. We accept Cash, Personal Check, MasterCard, and VISA.
- Any balances that are applied to your deductible must be paid in full before the next office visit.
- 24-hour notice of appointment cancellation is required. A cancellation fee of $25 will apply for missed appointments if a 24-hour notice is not given. Multiple no shows will be subject to dismissal.
- We must have a parent or legal guardian present for well checks and vaccinations.
- Minors under the age of 18 years, must be accompanied by a parent or adult with authorization.

Please sign here that you have read this office policy and agree to it.

____________________________________ ____________________
Parent or Legal Guardian *Date*

Electronic Prescription and Retrieval Consent

Dripping Springs Pediatrics (DSP) uses as electronic medical record (EMR) system that allows electronic prescribing of medications. Medications are sent to your pharmacy and insurance company through a secure electronic prescribing connection, which improves the timely and accurate transmission of the patient's medication information. To optimize the use of the EMR capability and to coordinate care between DSP and specialist, we ask that patient's allow us to access their medication history through the pharmacies and insurance companies electronic database.

The privacy of your Personal Health Information (PHI) contained in all prescriptions, whether written of electronic is protected by Federal and State laws. The Health Insurance Portability and Accountability Act (HIPAA) requires that your PHI be shared only for the purpose of providing patient clinical care. E-prescribing meets this requirement.

If you do not want your prescription sent electronically, or your pharmacy does not support e-prescribing, DSP can print the prescription.

Please check ONE of the following:

O I consent to allow the provider to access all of my/ my child's medication history
O I consent to allow the provider to access only medications prescribed in this office
O I DO NOT consent to the provider accessing ANY of my/ my child's medication history

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____________________________________ ____________________
Parent or Legal Guardian Date

CONSENT FOR TREATMENT

I hereby authorize evaluation and treatment by the physicians and staff associated with Dripping Springs Pediatrics. I understand and agree that the signatures and dates on this form will not expire without written notice or in the case that a minor becomes the age of 18, and that a photograph of this form is considered as valid as the original.

______________________________	______________________________
Parent or Legal Guardian	*Date*

NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please see the receptionist for a copy.

Revised for changes to take effect 9/23/2013

Understanding Your Health Record/Information

Each time you visit a hospital, physician or other Health care provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- basis for planning your care and treatment
- means of communication among the many health professionals who contribute to your care
- legal document describing the care you received
- means by which you or a third-party payer can verify that services billed were actually provided
- tool in educating health professionals
- source of data for medical research
- source of information for public health officials charged with improving the health of the nation
- source of data for facility planning and marketing
- tool with which we can assess and continually work to improve the care we render and the outcomes we achieve

Understanding what is in your record and how your health information is used helps you to

- ensure its accuracy
- better understand who, what, when, where and why others may access your health information
- make more informed decisions when authorizing disclosure to others

Your Health Information Rights

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to:

- request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522
- obtain a paper copy of the notice of information practices upon request
- inspect and obtain a copy of your health record as provided for in 45 CFR 164.524
- amend your health record as provided in 45 CFR 164.528
- obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528
- notified upon a breach of any of your unsecured Protected Health Information.
- request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to the HIPAA compliance officer. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.
- ***Out-of-Pocket-Payments.*** If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.
- request communications of your health information by alternative means or at alternative locations
- revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

This organization is required to:

- maintain the privacy of your health information provide you with a notice as to our legal duties and privacy
- practices with respect to information we collect and maintain about you
- abide by the terms of this notice
- notify you if we are unable to agree to a requested restriction
- accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations

We will not use or disclose your health information without your written authorization, except as described in this notice.

To Report a Problem

If you have questions and would like additional information, you may contact the Privacy Officer at this office. If you believe your privacy rights have been violated, you can file a complaint with this office or with the secretary of Health and Human Services. There will be no retaliation for filing a complaint.

Uses and Disclosures of Protected Health Information

Treatment: Information obtained by a nurse, physician or other member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your healthcare team. Members of your healthcare team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment. We will also provide subsequent healthcare providers with copies of various reports that should assist them in treating you.

Payment: A bill may be sent to you or a third- party payer. This information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures and supplies used.

Health Operations:

1. **Risk Management** - Members of the medical staff or the risk or quality improvement staff may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.
2. **Business Associates -** There are some services provided in our organization through contacts with business associates. Examples include radiology, laboratory, copy services, transcription services, billing services, etc. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we have asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.
3. **Notification –** We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, of your location and general condition.
4. **Communication With Family -** Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.
5. **Research -** We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.
6. **Funeral Directors –** We may disclose health information to funeral directors consistent with applicable law to carry out their duties.
7. **Organ Procurement Organizations** – Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking or transplantation of organs for the purpose of tissue donation and transplant.
8. **Marketing –** We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.
9. **Food and Drug Administration (FDA) –** We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, recalls, repairs or replacement.
10. **Workers' Compensation –** We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs established by law.
11. **Public Health –** As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.
12. **Law Enforcement –** We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.
13. **Fundraising** - If we use or disclose your protected health information for fundraising activities, we will provide you the choice to opt out of those activities. You may also choose to opt back in.

Uses and Disclosures that Require your Authorization

Other Permitted and Required Uses and Disclosures will be made only with your consent authorization or opportunity to object unless required by law.

1. **Marketing -** Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes.
2. **Sale -** We may not sell your protected health information without your authorization.
3. **Psychotherapy Notes** - We may not use or disclose most psychotherapy notes contained in your protected health information.
4. **Genetic Information** - We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

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ACKNOWLEDGEMENT OF
RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have received a copy of the ***Notice of Privacy Practices***.

____
Signature of patient or personal representative

____
If signed by personal representative, relationship to patient

____
Date

Office Use Only:

Our practice will make a good faith effort to obtain a written acknowledgement or receipt of the Notice provided to the individual. If written acknowledgement is not obtained, our practice must document its good faith efforts to obtain such acknowledgement and record the reason why the acknowledgement was not obtained.

Refused to sign ☐ Physically unable to sign ☐

(Other)

____

____

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Employee Signature: ______________________________

Date: ______________________________