Dripping Springs Pediatrics
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Financial Policy

Effective January 1, 2026, Dripping Springs Pediatrics has updated its financial policy and ask that you read and sign the following:

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 a current 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)* ***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:***

***Insured*:** 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.

***Self-pay*:** Patients **must pay in full at the time of service** unless arrangements have been made prior to the appointment. Please note the **self-pay discount applies to services paid in full at the time of service and not to payment arrangements**.

***Newborns*:** Please note it is the responsibility of the parents to **make sure a newborn is added to the insurance policy within the first 48 hours of birth**. Dripping Springs Pediatrics is not responsible nor are they allowed to handle any enrollment issues you may have with your insurance. If the parent/ guardian does not add the baby to the insurance in a timely manner, insurance claims may be denied, resulting in the parent or guardian taking full responsibility of payment to Dripping Springs Pediatrics for the entire billed amount.

_____*(initial)* ***Divorce:*** After a divorce or separation, **the parent accompanying and 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***: The time for your child's appointment has been set aside just for your child. It is difficult for us to fill this clinic slot with short notice. If you are too late to the appointment or if there is not a cancellation 24 hours prior to the appointment time, there will be a no-show charge applied to the account as follows:

Appointment Time allotted	No-show charge
Sick visits	**$50**
Well Child visits and medication follow ups	**$75**
Evaluations for Integrative, ADHD, Asthma, mental health or multifactorial concerns	**$100**

Patients with three missed appointments, may be considered for discharge from the clinic.

_____*(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 as a courtesy by one of our providers there is a **$35.00 charge in addition to your copay.** This is not covered by insurance and will be collected at time of service.

_____*(initial)* ***Returned Checks:*** There is a fee **(currently $40) for any checks returned by the bank.** If we received more than one returned check on an account you will be required in the future 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 will refund the guarantor of an account in a reasonable time period where a credit is due. The guarantor will be notified that a refund check has been issued and will be available for pick up. Checks should be cashed within 30 days of receipt.

_____*(initial)* ***Transferring of Records:*** You will need to request in writing, and pay a reasonable fee (currently **Paper copies of records may be obtained for $25 for the first 20 pages and 0.50 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 as well as additional postage fees. **Digital records may be obtained for a $25 fee** plus additional postage fees if required. 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 for each additional copy, there is a $5 fee assessed. If you are requesting your records be transferred from another doctor to us, you authorize us to receive all relevant information.

_____*(initial)* ***Labs:*** We do not bill for any send out laboratory testing, but specimen handling charges will apply and will be billed to insurance or Self-pay. Any labs sent from our office are sent out to CPL. For Quest or Lab Corp, you must inform us prior to labs being processed and sent. **If you do not inform us of a specific lab requirement by your insurance, you will be responsible for the laboratory bill through CPL.**

_____(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)* ***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 and acknowledge that fees may be subject to change.

Patient's Name (please print): _____

Responsible Party (please print): _____

Signature: _____

Co-Signor (please print): _____

Co-signature: _____

Received by: _____ Date: _____