Dripping Springs Pediatrics
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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. I**f 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: _____