



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 scheduling an appointment, presenting for care, or receiving services from Dripping Springs Pediatrics on or after January 1, 2026, you acknowledge receipt of this Financial Policy and agree to its terms, whether or not a written signature is obtained.**

\_\_\_\_\_ (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. While we assist by submitting claims as a courtesy, patients are ultimately responsible for understanding their insurance benefits. **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 practice after reasonable written notice and in compliance with applicable patient abandonment laws 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.** Insurance contracts require these amounts to be collected at the time of service.

**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 reasonable collection costs which are incurred.** If the account is referred to an attorney, you agree to pay reasonable attorney's fees and court costs as allowed by law. 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, limited information may be disclosed as permitted by applicable state and federal law, and the fact that services were rendered 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 late or fail to cancel or reschedule at least 24 hours prior to the appointment time, the following no-show fees will apply. These fees are not covered by insurance and are the patient’s responsibility.

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

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 \$15 fee 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. Returned check may be subject to collection or other remedies permitted by Texas law.

\_\_\_\_\_ (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. Please cash refund checks promptly, ideally within 30 days of receipt. Uncashed checks may be handled in accordance to Texas unclaimed property laws.

\_\_\_\_\_ (initial) **Transferring of Records:** Fees for copies of medical records will be assess as follows and will not exceed amounts permitted under Texas law. 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:** January 1, 2026

***I hereby state that I have read and understand the Financial Policy given to me by DRIPPING SPRINGS PEDIATRICS. A signed acknowledgment is requested but is not required for this policy to be effective.***

Patient's Name (please print): \_\_\_\_\_

Responsible Party (please print): \_\_\_\_\_

Signature: \_\_\_\_\_

Co-Signor (please print): \_\_\_\_\_

Co-signature: \_\_\_\_\_

Received by: \_\_\_\_\_ Date: \_\_\_\_\_