Patient Name _____ DOB _____ M/F

ALLERGIES: _____ _____

DAILY MEDICATIONS: _____

Patient(s) live with: MOM DAD BOTH Other :_____ Siblings:_____

Tell us about Mom (or guardian 1):

Name: _____

SS# _____ DOB_____

DL# _____ State _____

Address:

_____

City _____ State/Zip Code: _____

Home #_____ ☐ Preferred

Cell #_____ ☐ Preferred

Is it ok to leave you a message? Yes No

Email: _____

Tell us about Dad (or guardian 2):

Name: _____

SS# _____ DOB_____

DL# _____ State _____

Address:

_____

City _____ State/Zip Code: _____

Home #_____ ☐ Preferred

Cell #_____ ☐ Preferred

Is it ok to leave you a message? Yes No

Email: _____

Insurance Company _____ Member ID #_____ Group #_____

Claims Address _____ Phone # _____

Subscriber _____ Relation to patient _____

As a courtesy, we will submit a claim for you. Please familiarize yourself with your benefit plan as it is a contract between you and your carrier. You may be responsible for more than just your copayment. **We do not bill secondary insurance under any circumstance. <u>All copays and deductibles are due in full at time of service.</u> You will be charged an additional $5.00 if you request we bill you. After hours visits require your urgent care copay.**

Please list anyone you authorize to seek medical attention for your child in your absence or in case of emergency.

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

I certify that this information is true and correct to the best of my knowledge. I understand I will be responsible for any charges incurred by my child not covered by insurance. I authorize Round Rock Pediatrics to bill and receive payment from my insurance carrier, and release necessary PHI in accordance with Federal Regulation.

Responsible Party Signature_____ Date _____

Responsible Party Print _____

Entered/verified by _____

ROUND ROCK PEDIATRICS

FINANCIAL AGREEMENT AND BILLING POLICIES

❖ INSURANCE

We are committed to providing the best possible care for your child. Therefore, we will file claims to your insurance on your behalf. This is a courtesy to you. Insurance coverage is not a substitute for payment and does not release you from financial responsibility.

- We **DO NOT** file secondary insurance, under any circumstance!
- Please be prepared to present your insurance card at each visit. If we do not have the information on file, we cannot file the claim. Therefore, you will be responsible for services.
- All insurance carriers are primary to Medicaid and Tricare. You will be responsible for your copayment at the time of service.
- All copayments and deductibles are due at the time of service. There will be an additional $5 charge for billing these to you.
- We offer discounted rates for self-pay accounts if paid in full at time of service.
- Any charge not covered by your insurance carrier and outstanding balances are due in full at your next visit or upon receipt of invoice, whichever comes first.

❖ COVERED BENEFITS

Not all procedures, medications, and supplies may be covered services by your insurance. It is important to familiarize yourself with your plan as it is an agreement with you and your carrier whom may change covered services at times. We are NOT responsible for your benefit coverage. However, we do routinely verify your coverage in an attempt to obtain your benefits.

❖ FINANCIAL ARRANGEMENTS

We do understand that occasional certain situations may prevent you from making a payment in full. We would be happy to discuss alternative payment arrangements should your account qualify. Should you have questions regarding your account, please call our main number (512)255-6033. Billing questions will be handled as quickly as possible. Please be prepared to leave your name, child's name, date of service and detailed message. We will research the claim before returning your call to ensure we have not billed you incorrectly.

- After 90 days of non-payment, your account will be processed for collections. Penalty and interest fees will be added to your account monthly. We do utilize a collection agency that report to all 3 credit bureaus.

THERE WILL BE A $35 FEE FOR ALL CHECKS RETURNED TO US IN ADDITION TO THE FEES CHARGED BY CHECKRITE AND YOUR BANK. ALL RETURNED CHECKS NOT PAID IN FULL WITHIN 30 DAYS ARE SUBMITTED TO THE DISTRICT ATTORNEY FOR PROSECUTION.

❖ ACCOUNT GUARANTOR

Even after a divorce, you are responsible for payment at the time services are rendered. We will not become involved in your custodial matters but will gladly provide a receipt for any payment made for your records.

❖ MEDICAL RECORDS

You are entitled to request a copy of your medical record. However, the original record is the property of the physician and will not be released under any circumstance. In accordance with Federal regulation, you must complete a HIPAA compliant request form in our office or at another medical practice. Federal and state regulation permits us to charge a fee for duplication and postage. Please allow 14 business days from the receipt of your payment to process your request.

- **THERE WILL BE A $25 FEE FOR COPYING AND TRANSFERRING EACH RECORD.**

Your clear understanding is important, so please feel free to ask any questions you have in regards to these policies

I, the undersigned have read and clearly understand the financial agreement and policies of this practice. I am aware policies may be amended periodically. I authorize Round Rock Pediatrics to bill and receive payment from my insurance carrier and release necessary PHI in accordance with Federal Regulation. My signature below is valid until revoked in writing.

_____ _____ _____

Signature of Guarantor Patient's Name (s) Date

ROUND ROCK PEDIATRICS

PRACTICE POLICIES

The following is an outline of the policies enforced in this office you should be aware of. Please take the time to read our policies and feel free to ask any questions you may have.

- Our regular office hours are Monday through Friday 9:00-12:30 and 1:45-5:00. Saturdays 9:00-10:30 for sick children.

Any appointments outside of these hours are considered urgent care and will require a higher copayment.

❖ APPOINTMENTS

We ask that you please call to schedule all appointments as we do not have walk-in hours. Please call our main number (512)255-6033 to schedule or voice message for appointments. This is the ONLY number answered after hours.

- Sick/injured children will be scheduled on the same day to prevent their condition from worsening. If the schedule is full, we will do our best to work you child in. Please be patient as your child will be seen in between scheduled patients.
- Well child care/physicals need to be scheduled 2-3 weeks in advance. During May-September, we have an increased demand for these appointments, so please schedule early.
- MEDICAID WELL CHECKS ARE ONLY SCHEDULED IN THE MORNING DUE TO ADDITIONAL PAPERWORK THAT THE STATE REQUIRES.
- ADD/ADHD is scheduled on Tuesday and Thursday's at 12:00 ONLY! These appointments can take up to 1 hour
- Special Concerns/Counseling appointments are scheduled Tuesday and Thursday at 4:15. They typically take 45 min.

❖ MISSED APPOINTMENTS

- Should you fail to keep the appointment you scheduled or provide 24 hours' notice of cancellation, you will be charged a $30 No-Show fee. This fee MUST be paid before your next appointment. This fee meets Federal and state guidelines as well as our contract with your insurance carrier. This fee is not covered by your insurance carrier. After 3 no-shows, we reserve the right to ask you to find another physician.

❖ AFTER HOURS

- Please call (512)255-6033 for all matters. It is the only line answered after hours.
- If you have an urgent medical need, you may have the physician on call paged.
- Please DO NOT page the physician for billing or general policy questions.

❖ PRESCRIPTION REFILLS

- All refill requests require 48-72 hours' notice prior to being filled.
- For faster service, please contact your pharmacy for all non-controlled substance (ADD/ADHD) med refills and have the pharmacy fax a refill request.
- ADD/ADHD or controlled substance refills CANNOT be called into a pharmacy. You must provide 48 hours' notice for these medications. A parent must pick up the prescription and have it filled within 20 days. There will be a $15 fee for all prescription re-writes.

❖ XRAYS, LABORATORY SERVICES AND REFERRALS

- Should you require labs or x-rays performed outside of our office, we will do our best to direct you to a facility that accepts your insurance. Most results are available after 48hours. We will contact you as soon as the results are reviewed. You may be required to schedule an appointment to discuss the findings.
- Almost all lab services are subject to co-insurance. This means you will likely be responsible for a portion of the charges for services as indicated by your insurance plan.
- Non urgent referrals may take up to 10 business days to process. Emergency referrals will be completed within 48 hours.

❖ HEALTH FORMS

- Health forms such as physicals, sports participation, and camp forms are best completed at your well check. We will complete the form for you at no charge at the time of your appointment if you present them to the nurse at the beginning of the visit. However, forms submitted outside of your appointment will require a 48 hour completion time and $5 fee. All FMLA forms require a $5 fee for completion.

ROUND ROCK PEDIATRICS

BERNADETTE M. BROWN, MD

1050 Meadows Drive #307
Round Rock, Texas 78681
(512) 255-6033 Phone (512) 255-1150 Fax

MEDICAL RECORDS AUTHORIZATION

I, _____, authorize Round Rock Pediatrics to release/request records on my child/self _____ DOB: _____.

REQUEST RECORDS FROM:

_____

_____

_____

_____

RELEASE RECORDS TO:

_____

ROUND ROCK PEDIATRICS
1050 MEADOWS DR
307
ROUND ROCK, TX 78681

_____

_____

If record is 15 pages or longer please mail

Records to be released: _____ Progress Notes _____ Labs _____ All Records

Reason for release: _____ Continued care _____ Moved to new area

_____ Insurance change _____ Changing Physician

_____ Other _____

I understand that by signing below I authorize Round Rock Pediatrics to release personal health information on my child, I understand that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Texas State Board of Medical Examiners.

Signature of Parent/Guardian/Self: _____

Printed of Parent/Guardian/Self: _____ Date: _____