pediatrix
UROLOGY OF CENTRAL TEXAS

PATIENT FINANCIAL POLICY

PATIENT NAME: *_____ **PATIENT DATE OF BIRTH:* _____**

To reduce confusion and misunderstanding between our patients and practice, we have adopted the following financial policies. If you have any questions regarding these policies, please discuss them with our staff. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

PAYMENT IS DUE IN FULL AT TIME OF SERVICE unless other arrangements have been made in advance by either you or your health insurance carrier. For your convenience we accept VISA, MasterCard, Discover, American Express, Care Credit, cash, and checks.

INSURANCE (PLEASE INITIAL)

*____ Insurance plans subject to a deductible will be charged $150 at Check-In and the balance collected at Check-Out.

*____ I acknowledge that I have disclosed all insurance coverages. My primary insurance will not pay the claim(s) if they suspect other insurance coverage.

*____ We have contracted with many insurers and health plans to accept assignment of benefits. This means we will bill those plans and will only require you to pay the authorized co-payment, deductible and/or co-insurance at the time of service.

*____ It is the responsibility of the guarantor to know the benefits associated with their insurance plan or coverage and to obtain all referrals and authorizations from the primary care physician, when applicable. **IF YOU DO NOT HAVE A CURRENT REFERRAL OR AUTHORIZATION ON FILE, YOU MAY BE ASKED TO RESCHEDULE YOUR APPOINTMENT.**

*____ In the event your health plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

*____ Surgery deposits are due 10 business days prior to surgery. If for any reason surgery needs to be canceled it must be done 10 business days prior to the surgery date or a **$150 cancellation fee** may be charged to the parents.

SELF-PAY PATIENTS

*____ If you do not have insurance you will be considered a self-pay patient. Before seeing the doctor you need to make a deposit of **$150.** If the ENTIRE account is paid in FULL we will apply a 30% discount to your account. If you are unable to pay the entire account in full you will not receive the 30% discount. You will also need to make payment arrangements at CHECK-OUT with a credit card to pay the balance in full within **3 months.**

*____ We use a billing service. For any billing questions call 512-600-0125 for assistance.

*____ Telemedicine fees are $175 for new patients and $150 for established patients.

We accept VISA, MasterCard, Discover, American Express, Care Credit, cash, and checks.

ESTIMATES

*____ Upon request, our staff provides an estimate of costs for services. However, the actual cost of services is established according to the level of care needed as determined by your provider.

FEES

*____ I understand that in the opinion of our Providers, the services or items that I have requested to be provided to me at Pediatrix Urology of Central Texas may not be covered under my insurance as being reasonable and medically necessary for my care. I understand my health insurance plan determines the medical necessity of the services or items I request and receive. If my plan determines these services and/or items are not reasonable and medically necessary for my care, I am responsible for payment for the services or items I received.

*____ I understand lab work is sent to a reference lab. Pediatrix Urology Of Central Texas will provide the reference lab your insurance information necessary to submit a claim. Any charges incurred are my responsibility to pay.

*____ **FEES FOR FORM COMPLETION:**
I understand I will be responsible for paying **$25** for forms completed by my physician or staff (Example: Disability forms, FMLA forms, etc.). There is a **$50** fee for Immigration forms/ letters.

*____ **FEES FOR "NO SHOW":**
I understand that a **$60** "no show" fee may be assessed for appointments that I do not keep.

I understand that a **$150** "no show" fee may be assessed for in-office procedure appointments and surgical center procedures that I do not keep.

Medicaid Members: No shows will be reported to your health plan.

*____ **FEE FOR MEDICAL RECORDS: $25**

I have read and understand the financial policy of the practice, and I agree to be bound by its terms. I also understand and agree that the practice may amend such terms from time to time.

NAME OF PATIENT *_____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY IF A MINOR *_____ **DATE** *_____

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Policy for Divorced or Separated Parents

Pediatrix Urology of Central Texas providers and staff are dedicated to our patients and to providing quality medical care to your child(ren). Our focus is on your child's medical, emotional, and psychological health. We are not party to or involved in any legal issues involving divorce, separation or custody agreements. Please read and sign the following so that we may provide care to your child(ren).

1. The physicians, nurses, medical assistants, office and billing staff will not be put in the middle of domestic issues or disagreements over the phone or in the office.
2. Please make decisions regarding appointments and office procedures **PRIOR** to visiting our practice.
3. Only in situations where there is a confirmed, documented **Court Order** will one of the parents be denied access to the minor child's health records or visits at the office. Pediatrix Urology of Central Texas must have a copy of this Court Order on file in the minor child's electronic chart.
4. If there is NOT a court order on file with our office, either parent or legal guardian can sign a "Consent to Treatment" form that authorizes any named individuals (grandparents, nannies etc.) to bring your child to our practice, be present during the visit, and consent to treatment during that visit. We will not be involved in any disputes regarding named individuals on the consent forms unless instructed by the court. Either parent or legal guardian can schedule an appointment for their child, be present for the visit and/or obtain a copy of the visit summary. We reserve the right to charge an administrative fee for copying records should the requests become excessive.
5. It is both parents' responsibility to communicate with each other about the patients' care, office visit dates and any other pertinent information relevant to the patient. It is not the responsibility of the provider to communicate visit information to each custodial parent separately. Our providers will not call the non-attending parent following visits.
6. Additionally, we will not call the other parent for consent regarding appointments scheduled, restrict either parent's involvement in the patient's care unless required by law, or tolerate appointment scheduling/canceling patterns of behavior between parents.
7. Furthermore, payments including copays, deductibles, coinsurance or any additional fees charged by your insurance are due at the time of service regardless of which parent is responsible for medical expenses. We are **not** a party to your divorce agreement. We will collect payment from the parent who brings the child to their visit. If the divorce decree requires the other parent to pay all or part of the the treatment costs, it is the authorizing parent's responsibility to collect from the other parent. Any disputes about payment that end up in the collections process will be due at the next time of service.
8. Should the issues that come between parents become disruptive to our clinic or there is non-compliance with this policy, we may immediately terminate the patient/provider relationship. Your PCP will be notified.

By signing this form, you agree to honor the above policy and understand that breaking this agreement may result in the discharge of your family from the practice.

Please List Children - Name and Date of Birth (DOB):

_____	_____	_____	_____
Child's Name	DOB	Child's Name	DOB
_____	_____	_____	_____
Child's Name	DOB	Child's Name	DOB

_____	_____	_____
Print - Parent/Legal Guardian	Sign - Parent/Legal Guardian	Date
_____	_____	_____
Print - Parent/Legal Guardian	Sign - Parent/Legal Guardian	Date