



## MD Pediatric Associates

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### Patient Financial Policy

This is an agreement between MD Pediatric Associates, 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 payment credited. The words “we,” “us,” and “our” refer to MD Pediatric Associates.

By executing this agreement, you are agreeing to pay for all services that are received.

**Monthly Statement:** If you have a balance on your account, we will send you a monthly statement. It will show the charges on your account and any payment or credits applied to your account.

**Payments:** Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid within thirty (30) days.

**Insurance:** Insurance is a contract between you and your insurance company. We are NOT a party to this contract, in most cases. Although our office is required to obtain any secondary insurance information, we DO NOT file secondary claims. That is the sole responsibility of the patient. We will bill your primary insurance company. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance.

**Re-billing Fee:** A re-billing fee of \$5 will be imposed on each account that is over thirty (30) days past-due.

**Required Payments:** Any co-payments, co-insurance, and/or deductibles are due in full at the time of service. Because this is an insurance requirement, we cannot bill you for these, regardless of who brings in the child for his/her appointment. For your convenience we accept VISA, MasterCard, Discover, and American Express.

**Returned Checks:** There is a fee (currently \$30) for any checks returned by the bank. The amount of the check and the returned check fee must be paid with cash, credit card, or money order ONLY. This amount must be paid before any children are seen for future appointments. If there have been three (3) returned checks with our office, we will no longer be able to accept payment by check. Future visits will require an alternate form of payment.

**Missed Appointment Fee:** We require advance notice of 24 hours for the following appointment types: Well Child Exams, ADD/ADHD, TCAMP, Consultations, and any type of Saturday appointment. Unless advance notification of 24 hours is received, a fee of \$25 will be assessed for Well Child Exams, and Saturday appointments. A fee of \$50 will be imposed for ADD/ADHD, Consultations, and TCAMP appointments. This fee must be paid before any children are seen for future appointments.

**Past Due Accounts:** If your account becomes past due, we will take necessary steps to collect this debt. This may result in referring your account to an outside collection agency.

Initials: \_\_\_\_\_

**Waiver of Confidentiality:** You understand if this account is submitted to a collection agency, the fact that you received treatment at our office may become a matter of public record.

**Divorce:** In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for the child will be the parent responsible for those subsequent charges. 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.

**Medical Records:** Medical records will be copied and released in compliance with HIPAA regulations. Charges for medical records are outlined on the medical release form.

**After Hours Advice:** If a phone call is made to us outside of normal business hours, your call will be forwarded to On Call For Kids, and a registered nurse will return your call promptly. A \$10.00 fee will be assessed for all after hours medical advice calls.

**Refunds:** Overpayments on accounts will be refunded at your request. If no such request is made, the overage will be applied as a credit to your account. If there is a patient due balance elsewhere on the account, the credit will be applied to the balance. You may use this credit for any services provided by our office.

**Medicaid Patients:** We are NOT providers for any type of Medicaid. However, we will accept Medicaid as a secondary insurance for acute care. A co-payment for acute visits will not be required if the child is enrolled in Medicaid, and we are provided with a current eligibility form. For any elective care appointments, you will be required to sign a "Private Pay" form designed by Medicaid. We will gladly file your primary insurance for these visits. Any charges denied or non-covered services will become your responsibility.

**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.

**Patients Names:** \_\_\_\_\_ **Birth Date:** \_\_\_\_\_  
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**Birth Date:** \_\_\_\_\_  
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**Birth Date:** \_\_\_\_\_  
\_\_\_\_\_  
**Birth Date:** \_\_\_\_\_

**Printed Name of Parent/Guardian** \_\_\_\_\_

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_