Tots to Teens Pediatrics
building healthy futures

619 W. FM 544, SUITE 1B
MURPHY,TX 75094
(972) 424-7915

PATIENT NAME: _____DATE_____DOB_____

STATEMENT OF FINANCIAL OBLIGATION

All payments are expected at the time of service. This office is contracted with many different insurance plans. We will be happy to file your insurance claims, however you will be expected to pay your co-pay, deductible and/or co-insurance due at each visit. We accept cash, card (Visa, Mastercard, Discover, American Express).

PRIMARY CARE PHYSICIAN

If you are required by your insurance company to select a primary care physician, this must be done prior to your child's appointment. Our mission as a practice is to provide for the health and well being of our patients. Your health insurance is a contract between you and your health insurance company. You are financially responsible for any noncovered services.

PRIVATE PAY PATIENTS

If you do not have insurance, payment is due at the time services are rendered. You may contact office prior to your visit to receive an estimated cost for treatment.

STATEMENT OF BENEFIT OBLIGATION

All patients are expected to provide our office with current insurance information and to understand their benefits. For the convenience of our patients our provider participates in a variety of managed care plans. This may include completeing pre-certifications, eligibility verifications or similar paperwork on behalf of the patients. Ultimately, the patient is responsible for understanding their benefits and providing our office with current information so that we can handle this paperwork on their behalf in a timely manner.

CANCELLATIONS & APPOINTMENT CONFIRMATIONS/NO SHOWS

If you should need to cancel a scheduled well visit notify our office **24 hours** in advance in order that we may accommodate families who are on a waiting list for an earlier appointment.Our office staff/automated calls to give you a curtiousey reminder of your appointment. Appointments missed/canceled less than 24 our prior to your scheduled time are considered no-show appointments. You may be charged a no-show fee of **$20.00.**

LATE POLICY

If you are going to be more than 15 minutes late, call our office so we can reschedule your appointment for a more convenient time. Please respect this policy as it ensures that the physicans and patients stay on time.

SICK & WELL CHILD APPOINTMENTS

Sick appointments are scheduled as same-day appointments only! We recommend scheduling a well child visit appointment 6-8 weeks in advance. This assures your child will have their well visits and immunizations on time.

MEDICAL/SHOT RECORD & SCHOOL FORMS

Our office has 15 business days to release your child's medical records. Please give our office 24-48 hours for your immunization records, sport physical form, and any other forms requested. It is also helpful to provide us with the name, address, phone number, and fax number of the person who needs this information.

I HAVE READ, UNDERSTAND AND WILL COMPLY WITH THE ABOVE POLICIES. I UNDERSTAND THAT I AM RESPONSIBLE FOR THE CHARGES OCCURRED BY MY CHILD/CHILDREN REGARDLESS OF INSURANCE BENEFITS. IF IN USING THE INFORMATION I HAVE PROVIDED TODAY OR ON PREVIOUS OCCASIONS, **TOTS TO TEENS PEDIATRICS** IS UNABLE TO COLLECT FROM MY INSURANCE COMPANY, I ACCEPT FULL RESPONSIBILTY FOR THE PAYMENT OF MY BILLS.

EMAIL:_____

PATIENT/GUARDIAN PRINTED NAME:_____

PATIENT/GUARDIAN SIGNATURE:_____**DATE**_____

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HIPPA Privacy & Release of Information Authorization

PATIENT NAME:_____DATE_____DOB_____

I **(PATIENT/GUARDIAN)** hereby authorize Tots To Teens Pediatrics Billing and its affiliates, its employees and agents, to use the disclose protection health information (e.g., information relating to the diagnosis, treatment, claims payments, and health care service provided or to be provided to me and which identifies my name, adress, social security number, member ID number) for the purpose of helping me to resolve claims and health benefit coverage issues.

I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.

I understand that that I have the right to revoke this authorization by providing written notice to. However, this authorization may not be revoked if, its employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of service. I have also been advised of this practice's Privacy Practices, Release of Billing Information Policy, Assignment of Benefits Policy, and grant the practice Medication History Authority. If applicable, Legal Representative sign below.

By signing, this form, I represent that I am the legal representative of the Member identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Member's behalf with respect to this authorization form.

PLEASE, NOTIFY US WITH ANY CHANGES TO YOUR
ADDRESS, PHONE NUMBER, AND INSURANCE INFORMATION.

FOR YOUR CHILD'S OWN PROTECTION EVERY PARENT MUST PRESENT THEIR
I.D. & INSURANCE CARD

ALL **CO-PAY, CO-INSURANCE, DEDUCTIBLES, AND OUTSTANDING BALANCES** ARE DUE UPON ARRIVAL

PHONE #_____

PATIENT/GUARDIAN PRINTED NAME:_____

PATIENT/GUARDIAN SIGNATURE:_____**DATE**_____