Bee Caves Pediatrics, P.A.
(512) 328-7666
(512) 328-3547 (fax)

Financial Policy

2499 S. Capital of Texas Hwy.
Bldg. B Ste. # 100
Austin, TX 78746

This is an agreement between Bee Caves Pediatrics, P.A., a Texas Professional Corporation, 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 Bee Caves Pediatrics, P.A. By executing this agreement, you are agreeing to pay for all services that are received.

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. 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. **Bee Caves Pediatrics will *NOT* file any claims for patients without an insurance card.** You can request your insurance company to fax you with documentation of insurance coverage that includes all billing information. You will need to provide this information every 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. If your insurance company requires a referral or preauthorization, you are responsible for obtaining it.

Labs: We do not bill for any specialty laboratory testing. We will take a specimen here and send it to Clinical Pathology Laboratories or LabCorp. If your laboratory designated by your insurance company is anything other than Clinical Pathology Laboratories or LabCorp you will need to find which lab is the closest for you to go have your lab work done there. Failure to do so can result in a heavy expense to you.

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 office if your account cannot be maintained in a fair equitable manner.

Required Payments: Any co-payments, co-insurance, or deductible amounts required by an insurance company must be paid at the time of service. Because this is an insurance requirement, we cannot bill you for these.

Divorce: After a divorce or separation, the parent 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.

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 of the collection costs, which are incurred. If we have to refer the collection balance to a lawyer, you agree to pay all lawyers' fees, which we incur, plus all court costs. In case of suit, you agree the venue shall be in Travis County, Austin, Texas.

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 you're past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Missed Appointment Fee: If a patient does not show up on time for an appointment, or does not cancel prior to the scheduled appointment time, a $20 fee will be charged. Patients with three missed appointments will be asked to transfer their records to another doctor.

After Hours Calls: After hours calls are directed to the Seton call center at (512) 324-3126. Please be aware that there is a $15 charge every time you call the Seton Call Center whether it is to seek advice or to have a doctor paged.

Returned Checks: There is a fee (currently $25) for any checks returned by the bank. If we received more than one returned check on an account you will be required to pay with a credit card, money order or cash. We reserve the right to submit your information to the legal authorities, as this is a crime in the state of Texas.

Transferring of Records: You will need to request in writing, and pay a reasonable fee (currently $25) to Bee Caves Pediatrics if you want to have copies of your records transferred to another doctor, organization, or for your own personal files. You authorize 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 each additional copy, there is a $5 fee assessed every time requested. If you are requesting your records be transferred from another doctor to us, you authorize us to receive all relevant information.

Co-signature: If another person signs this or another Financial Policy, that co-signature remains in effect until canceled in writing. If written cancellation is received, it becomes effective with any subsequent charges. It does not release them from responsibility of any prior charges that were incurred.

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.

I hereby state that I have read and understand the Financial Policy given to me by Bee Caves Pediatrics, P.A.

Patient's Name (print): _____

Responsible Party (print): _____

Signature: _____

Co-Signature (print): _____

Signature: _____

Received by: _____ ***Date: _____***