North Pediatrics Patient Information

3142 Horizon Rd, Suite 200, Rockwall, TX 75032 | Ph/214-306-4456 F/214-306-4457

Child's Name:_____DOB:_____
First Middle Last

Financial Policies

- North Pediatrics is not responsible for determining if we are on your insurance plan. It is your responsibility to contact your insurance plan for this information.
- All co-pays are due at time of service regardless of whom brings the child; babysitters, grandparents, older sibling, nannies, etc. must be prepared to pay the co-pay.
- If you do not have insurance, or have a deductible that has not been met, payment in full is expected at time service is rendered. All self-pay amounts will be collected during the check-in process.
- If our office is not notified of insurance changes within 30 days of the date of service, the account holder will be expected to pay in full for all charges for that date of service.
- Claims denied, or any service not covered or considered not a benefit by insurance companies, will be billed to the responsible party. If there are any questions, you may dispute them with your insurance company.
- We accept cash, personal checks, Visa, MasterCard, Discover, and American Express. We charge $40 for all returned checks.
- We reserve the right to charge $25 for missed or late canceled appointments. Insurance will not pay for this fee; therefore, it is patient responsibility. Please call the office at least 24 hours in advance if you need to cancel or reschedule your appointment so we can offer the appointment to another patient. Excessive abuse of scheduled appointments may result in discharge from the practice. We do enforce a strict missed appointment policy.
- We charge $50 if we forward to our account to a collection agency.
- You agree, in order for us to service our account or to collect any amount you may owe, we may contact you by telephone at any telephone number associate with your account, including wireless telephone number, which could result in charges to you. We may also contact you by sending text messages or email, using any email address you provide to us. Methods of contact may include using preL recorded/artificial voice messages and/or use of an automatic dialing service, as applicable. I/We have read this disclosure and agree that the practice and/or creditor may contact me/us as described.
- Please be prepared to show form of ID and Insurance card at every visit.
- Please make sure all information with your insurance is correct. We are required to file our claims to match your insurance (ie: name, DOB etc).
- Divorced /Separated Families: Payment is the responsibility of the parent who brings the child in to the office for treatment, regardless what the divorce decree states. This is a matter between the parents and the court system. We will not be placed in the middle of financial agreements made by these court orders.

I have read and agree to the financial policies of North Pediatrics. I assign insurance benefits to be paid directly to North Pediatrics. I understand that I am financially responsible for all non-covered services performed that are not covered under the terms of my health care coverage. I authorize the release of medical information on the patients to their insurance companies for the purpose of filing insurance claims.

Printed Name of Parent/Legal Guardian_____

Signature of Parent /Legal Guardian_____Date_____

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General Office Policies

- Physician assessment will be needed for all antibiotics and/or refills, referrals, and to complete signed paperwork. A current well child visit also needs to be up-to-date.
- If you arrive late for your appointment, we reserve the right to reschedule your appointment. Late arrivals will cause a delay in seeing patients who are on time. If you find that you are running late, we recommend that you call our office to determine if we can hold your appointment time.
- We require 48 hours notice to refill all prescriptions.
- If a child has a name change, we will need documentation stating as such.
- Asthma patients will need to be assessed every 3 months in order for medication to be refilled.
- All ADHD patients need to be assessed every 3 months; may be more/less often depending on provider recommendation.
    - Please keep track of your medication and call before running out.
    - Bring your drivers license when you pick up prescription – signature required – and you must be 18 years of age.
    - Give our office at least 48-72 hours notice for all ADHD refills. Please do not wait until the last pill.
    - A $10 fee will be added for all prescriptions that need to be re-written
- North Pediatrics will charge $25 for each missed appointment. Please call our office if you are unable to keep your scheduled appointment.
- Three missed appointments in a one-year period may result in dismissal from the practice.
- No medical records will be released without written communication from parent/guardian.
- Verbal abuse of our staff will not be tolerated.

I have read and agree to the office policies of North Pediatrics.

Printed Name of Parent/Legal Guardian_____

Signature of Parent /Legal Guardian_____Date_____

Vaccination Policy

As medical professionals, we feel very strongly that vaccinating children on schedule with currently available vaccines is absolutely the right thing to do for all children and young adults. If your child has received any vaccinations at any place other than our office, your must provide us with proof of vaccination. If you should absolutely refuse to vaccinate your child, we will ask you to find another health care provider who shares your views. We do not keep a list of such providers nor would we recommend any such physician. Please recognize that by not vaccinating you are putting your child at unnecessary risk for life-threatening illness and disability, and even death.

Printed Name of Parent/Legal Guardian_____

Signature of Parent /Legal Guardian_____Date_____

Authorizations – please initial

_____I authorize North Pediatrics to download medication history automatically from Pharmacy Benefit Managers (PBMs)

_____ I agree to receive automatic phone calls from North Pediatrics, which may include appointments, test results and more, on any devices I have listed, including mobile devices.

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HIPPA- Privacy Policy

I have read or have access to read the privacy policy for North Pediatrics.

Printed Name of Parent/Legal Guardian_____

Signature of Parent /Legal Guardian_____Date_____

Consent for Treatment of Minor

In accordance with Texas Law, North Pediatrics will not provide healthcare to minors unless they are accompanied by a parent, have a parents written consent, or provide a way for North Pediatrics to contact the parent (unless under special conditions as listed below). North Pediatrics will provide healthcare to a minor without consultation with the parent or guardian if any of the following conditions exist:

- Child abuse (emotional, physical, sexual) is suspected.
- The adolescent is seeking treatment for drug and/or alcohol abuse.
- The adolescent is seeking treatment for sexually transmitted disease
- Suicidal ideations
- Immunizations to prevent the spread of sexually transmitted diseases.

If the parent having the right to consent cannot be contacted, the following persons listed below may consent to medical treatment unless parent has given notice to the contrary: Relative: Grandparents, Adult Siblings, Aunt, or Uncle.

No one else can consent to medical treatment of a minor without written consent of the parent. This includes schools, any other adult, or any court not having jurisdiction over the child.

In Texas, a patient is considered a "Minor" if he/she is under the age of 18 years, has never married, or has not been declared a legally emancipated minor.

If you have any questions, please call the Texas Department of Health, 512-458-7111 ext 2021

Parent or Legal Guardian Consent for Treatment of Minor

I give my written consent for the following people to accompany my child to North Pediatrics for medical treatment in my absence:

Name:	**Relationship:**	**Phone#:**
_____	_____	_____
_____	_____	_____
_____	_____	_____

Printed Name of Parent/Legal Guardian_____

Signature of Parent /Legal Guardian_____Date_____