Wildflower Pediatrics, PA
11609 Anderson Mill Road
Austin, Texas 78750

WILDFLOWER PEDIATRICS FINANCIAL POLICY

Patient Name: _____ DOB: _____

Thank you for selecting Wildflower Pediatrics as your healthcare provider. Our personnel will be happy to discuss our fees and this policy with you at any time. Please read and sign this financial policy prior to seeing the physician. Payment for services is due at the time services are rendered. For any portion of your balance that is not covered by insurance, or for our private pay patients we accept cash, check, all major credit cards (including apple pay). Self-pay patients that pay in full at the time of service will receive a 40% discount.

Your insurance policy is a contract between you, your employer, and the insurance carrier. We are NOT a party to that contract. Our relationship is with you. We cannot become involved in disputes between you and your insurer regarding deductibles, co-payments, covered charges, secondary insurances, and "usual and customary charges." We are, however, contracted with most managed care plans. Please present your insurance card at the front desk so that we can file a claim on your behalf. We will follow their guidelines for submission of claims, copay amounts, and reimbursements. Any contractual provider discounts will be deducted from your balance.

All charges are your responsibility whether your insurance company pays or does not pay. Not all services are a covered benefit in all contracts. Some insurance companies and some employers decide what a covered benefit is and what is not. Please check your insurance plan document for any questions. Fees for these services along with unmet deductibles and co-payments are due at the time of treatment.

Please be aware that your health insurance may not cover services or discussions related to medical conditions or chronic issues as a part of your well check visit. Additional issues that are discussed outside of well care may result in an additional charge, copay, or deductible/coinsurance amount depending on your insurance plan. Any services that are not considered as part of a routine well exam/visit will be billed out as a separate charge.

Co-payments not paid at the time of service are subject to a $10 processing fee. All balances more than 60 days past due are subject to a penalty of $10 per month to cover the cost of sending additional statements.

If your insurance company does not pay your claim within 30 days, it is your responsibility to contact your insurer to expedite payment. If your insurance company does not pay in 60 days, you will be responsible for payment.

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Returned checks and balances older than 90 days may be subject to collection placement and collections fees which will be charged to the responsible party. If we are forced to send your account to a collection agency, a 40% fee will be added to your balance.

Please note that all cancellations for scheduled appointments must be made at least 24 hours in advance, which allows us to care for other patients in need of our services. If you fail to cancel your appointment, you may be charged a $25 service fee which will not be covered by your insurance plan. Arrival of appointment later than 15 minutes will be rescheduled unless the Providers schedule allows for the tardiness.

There will be a $35 NSF charge on all returned checks.

Occasionally an insurance payment results in overpayment on your account and generally this balance remains on your account as a credit for use at a future visits. You may request a refund of overpayment by notifying the office manager.

AFTER HOURS PHONE CALLS (Monday – Friday AFTER 4:30pm, weekend, and holidays): There is a $30 charge for after hour nursing or doctor call consultations provided by our after-hours nursing line. We will directly bill you for this charge.

CHILD CUSTODY/DIVORCE:
Our office will NOT get involved in disputes related to parent responsibility on the account. We are not able to mediate financial issues or obligations between our office and the patient's guardian in cases of separated/divorced parents or custody issues. The parent bringing in the child at the time of service will be deemed the responsible person and payment will be due at time of service according to the above billing procedures. Statements will be billed out to the adult insured listed on the patient's account. Payment for balances due at time of service must be handled through the patient's parents/guardians, not our office staff. Please provide us with any legal documents that explain any judgment changes regarding these issues for your child's chart.

I give permission to Wildflower Pediatrics to convert any paper check or check by phone to an electronic transmission.

Again, thank you for choosing Wildflower Pediatrics. We appreciate the opportunity to serve you.

Parent Name: (please print) _____
Parent Signature: _____
Date: _____

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FINANCIAL RESPONSIBILITY

I understand that my primary insurance company will be billed for me but that all co-pays, co-insurance, non-covered items and amounts are due at the time of service. I also understand that if my insurance company denies a charge for any reason, I will be billed and ultimately responsible for that charge. In addition, if a claim is disputed by the insurance company for any reason, and payment has not been made in a timely manner, I will be responsible for the payment of the charges until the dispute has been resolved and the insurance company makes payment of the charges in question. Lastly, I authorize insurance benefits to be paid directly to the physician and the release of any medical records that may be required by the insurance company in order to pay out those benefits. This assignment of benefits is irrevocable, and a photo static copy shall be considered as legal and binding as the original. In the event of default for any reason, parent/guardian is responsible for any and all attorney fees, collection fees, and all courts costs.

WHO IS FINANCIALLY RESPONSIBLE

Name: _____ DOB: _____
Address: (if different from patient's) _____
City: _____ State: _____ Zip Code: _____
Relationship to Patient: _____

POLICY HOLDER AND INSURANCE INFORMATION

Payment Method
[ ] Insurance
[ ] Self Pay
(please check one)

If Insurance is selected, please provide the following information:

Primary Insurance:
Name of Insurance Company: _____
Subscriber Name: (policy holder) _____
Subscriber DOB: _____
Identification Number: _____
Group Number: _____

Secondary Insurance (if applicable)
Name of Insurance Company: _____
Subscriber Name: (policy holder) _____
Subscriber DOB: _____
Identification Number: _____
Group Number: _____