

Treehouse Pediatrics
15930 S. Great Oaks Dr., Bldg. B
Round Rock, TX 78681

OFFICE POLICIES

Regular office hours are Mon. through Fri., 8:00am to 5p.m., and Saturday 8:30-12:30 p.m.

Weekend and after hour triage calls are available for medical advice. There is a \$13.00 phone charge for this call.

To cancel or reschedule an appointment, please notify the office within 24 hours in advance. This will allow us to see other patients who need our services. You will be charged a \$30.00 fee if you "no-show".

Requests for school, day care, immunization records, etc. usually require 48 hours to complete.

For a prescription refill, please allow 48 hours. This means you should call us, or have the pharmacy call, two days prior to the empty refill.

To transfer out medical records, we require a payment of \$15.00 per child or \$25.00 family.

PAYMENT/BILLING INFORMATION

Co payment is required at the time of the office visit. There is a \$5.00 service fee if payment is not made at this time.

There is a returned check fee of \$25.00 should your payment not clear the bank.

Billing statements are sent out each month. Any balance not covered by your insurance must be paid in full before the next appointment. Unpaid balances over 90 days may be turned into collections, and additional fees will be assessed.

If your balance is high, due to hospital deductible or financial issues, please meet with the office manager to establish a payment plan option.

For your convenience, we accept cash, check, Visa or Master Card.

Private pay families are offered a 20% discount off the visit balance. All balances must be paid in full at the time of the service.

INSURANCE INFORMATION

As a courtesy to our patients we have enrolled in many managed care programs. However, we do not take responsibility for items that are not covered by your individual plan.

We will not file any claims for patients without an insurance card. You can request your insurance company to fax or provide you with insurance documentation of coverage that includes all billing information. We will not be responsible for any denied claims due to filing deadlines if new insurance was not given at the time of service.

Prior to the office appointment, please be sure that you have contacted your insurance company to add your new baby/child to the insurance policy. If the claim is denied, you will be responsible for payment.

It is advised that all patients verify (if not already known) to see if we are a network provider for your insurance. Also, check which lab your insurance company is contracted with.

NEWBORN INFORMATION

Contact your insurance company immediately after your baby is born. It is important that the baby's name be added to the policy within the first 31 days. Many insurance companies will not pay (after the fact). You could end up responsible for any charges not covered.

Please inform us when making your first appointment which insurance you will be adding your baby to.

If your baby is not added to your insurance by the first well exam, you will be considered private pay until we can verify coverage.

If your plan is an HMO or requires a selection of a Primary Care Physician, please specify that our doctor be designated, prior to the scheduled appointment.

Know your benefits! It is important that you understand what coverage is available for your child. Find out if you have well child and/or shot reimbursement. Many plans have limited coverage regarding preventative care. Know what your co pay or deductible amount is. Free shots are available if you do not have immunization coverage or if you are underinsured (i.e. limited \$\$ amount for well child coverage.) Ask the front office staff for the state form and sign it before your child is examined.

E-Mail Address: _____ How did you hear about our practice? _____

PATIENT INFORMATION		
First Name _____	Middle Initial _____	Last Name _____
Mailing Address _____	City/St _____	Zip _____
Birth Date _____	Boy _____ Girl _____	Primary # to call for appointment reminders # () _____

A COPY OF YOUR INSURANCE CARD IS REQUIRED, AND ALL INFORMATION ON THIS FORM MUST BE COMPLETED.

PRIMARY INSURANCE (MUST BE FILLED OUT COMPLETELY)		
Subscriber's Name _____	Mailing Address _____	
City/St _____	Zip _____	Birth Date _____ Relationship to Patient _____
Social Security # _____	Employer _____	Ins. Member ID# _____
Group # _____	Name of Insurance _____	

SECONDARY INSURANCE (Write none, if applies)		
Subscriber's Name _____	Mailing Address _____	
City/St _____	Zip _____	Birth Date _____ Relationship to Patient _____
Social Security # _____	Employer _____	Ins. Member ID# _____
Group # _____	Name of Insurance _____	

This section below MUST be completed to include: contact information for both parents.

Check one: <input type="checkbox"/> Parent <input type="checkbox"/> Step-Parent	Check one: <input type="checkbox"/> Parent <input type="checkbox"/> Step-Parent
Father's Name _____	Mother's Name _____
SS # _____ Birth Date _____	SS # _____ Birth Date _____
Primary # () _____ Work # () _____	Primary # () _____ Work # () _____
Home # () _____ Cell # () _____	Home # () _____ Cell # () _____
Complete, if address is different than child's listed above:	Complete, if address is different than child's listed above:
Mailing Address _____	Mailing Address _____
City _____ St _____ Zip _____	City _____ St _____ Zip _____

• I understand that, even though I may have some type of insurance and authorize this office to submit charges on behalf of my child, I am also responsible for payment. I hereby assign to the doctor, all payments for medical services rendered to my dependent. I am aware that **co payment is required at each visit**, and if there is no insurance coverage, **payment in full** is required for services provided unless prior payment arrangements have been discussed. **I will also be responsible for all collection fees, should my account be assigned to a Collection Agency.**

Signature _____ Date _____

Treehouse Pediatrics – Insurance Verification

Patient Name: _____

Date of Birth: _____

We are doing everything possible to hold down the cost of medical care. We believe it's your responsibility to know your benefit plan – especially immunization coverage.

Filing Claims – If we have a current card, and we can verify active coverage, we will file the claim for you. If not, payment is expected at the time of the visit.

Insurance – Before your appointment, our office will verify with your insurance plan to ensure that you:

- Have **active** coverage,
- Your dependents are **added**,
- **Payment amount** to be collected (co-pay or co-insurance),
- **Available coverage** (sick and well),
- We do **NOT** ask about insurance “specifics”
 - Many plans have a yearly limit of visits either well or sick, also maximum \$\$ amounts or out of pocket expenses to meet.

Between the ages of birth – 4 years, the average well check w/vaccines is approximately \$500.

You need to know if you have coverage!

State Vaccines – If you cannot afford to pay for vaccines, have a high deductible plan or limited coverage, you may qualify for the “Texas Vaccines For Children Program”. Please ask the receptionist or nurse for a form **BEFORE** the office visit.

Payment – Co-payments or patient balances **MUST** be paid at the time of the visit unless prior payment arrangements have been made.

I have read the insurance verification process. I understand that any amount billed to my insurance becomes my responsibility if procedures are not covered. If it becomes necessary to forward my account to a collection agency, I will also be responsible for the fee charged by the agency.

Signature: _____

Date: _____

Treehouse Pediatrics

15930 Great Oaks Drive, Bldg., B Round Rock, TX 78681 (512) 255-8868

OFFICE POLICY – Please Read Carefully

- Copayment is due at the time of service unless prior arrangements are made. We accept Cash, Personal Check, MasterCard and Visa. **If copayments are not paid, a \$5.00 service fee will be charged.**
- A new patient that has **not met their deductible** will be required to pay the entire first visit at the time of service.
- Any balances that are applied to your deductible must be paid in full before the next office visit.
- **There is a \$13.00 fee for any after hour phone call to the doctor or triage center. This fee is waived if it becomes necessary to go to the Urgent Care or Emergency Room.**
- *24 hr notice of appointment cancellation is required or a \$30.00 cancellation fee will be charged.* Multiple no shows will be subject to dismissal.
- **We do not take any new Medicaid patients**, although temporary exceptions may be made for existing patients. Please ask to speak with the Office Manager.

Please sign here that you have read this office policy and agree to it.

Parent or Legal Guardian

Date

CONSENT FOR TREATMENT

I hereby authorized evaluation and treatment by the physicians and staff associated with Treehouse Pediatrics. I understand and agree that the signatures and dates on this form will not expire without written notice or in the case that a minor becomes the age of 18, and that a photocopy of this form is considered valid as the original.

Parent or Legal Guardian

Date

CONSENT TO SEE PATIENT – WITHOUT PARENT PRESENT

I hereby authorize _____ to bring my child to
Name/Relationship

his/her appointments if I am unable to attend. I understand that medical advice will be relayed to them on my behalf.

Parent or Legal Guardian

Date

TREEHOUSE PEDIATRIC

15930 Great Oaks Drive, Bldg., B Round Rock, TX 78681 (512) 255-8868

Anselmo Unite, MD
Debaroti Addy, MD
Ting-Chuan Chang, MD
Wade Travis, MD

ACKNOWLEDGEMENT OF RECEIPT

I have been given the opportunity to read and receive a copy of the Practices' Notice of Privacy Policy.

Signature

Date

I understand that TreeHouse Pediatrics will only use and/or disclose protected health information (PHI) for treatment, payment or healthcare operations.

Signature

Date

Please list all children in our practice.

NAME	DATE OF BIRTH