Bluebonnet Pediatrics
790 Generations Drive Suite 215
New Braunfels, Texas 78130
Phone: 830-333-9533 Fax: 877-268-6904

Financial Policy- Patient Copy

- I agree to pay the following fees that are ***NOT BILLED TO INSURANCE***

  $50.00 No Show/ Same Day/Less Than 24 Business Hour Cancellation Fee

  $35.00 Spot Vision Fee

  $10.00 Immunization Record Fee (per record) / $15.00 Express Immunization Record Fee (per record)

  $15.00 Form Fee (per form)/ $25.00 Express Form Fee (per form)

  $20.00 Express Medication Refill Fee

  $25.00 Walk in Fee/Sibling Add on Fee

  $40.00 After Hours/on Call Physician Fee

  $25.00 Medical Records Fee- for all medical records request

  $35.00 Form Fee for FMLA Paperwork

  $10.00 Statement Fee- for each additional statement after the first statement

- I understand and agree to the following office policies
  - **Well Visit:** My child needs a yearly well child check to remain a patient at Bluebonnet Pediatrics
  - **Forms:** Allow 10 business days for form completion, child will need to be up to date on yearly well child check and immunizations.
  - **Medication Refills:** Allow 5 business days for medication refills
  - **Immunizations:** Refer to separate IMMUNIZATION POLICY (Page 6)
  - **Appointments:** Patients are seen by appointment only during posted office hours. Please give a minimum of 24 business hours for all cancellations and reschedules to avoid no show/same day/less than 24 business hour cancellation fee. Patients more than 15 minutes late that are not able to be worked into the schedule may have to be rescheduled.
  - **ADHD/MOOD Appointments:** Must be seen every month until medication dosage is established and then every 3 months.
  - **After Hours:** 210-22-NURSE may answer any clinical questions. The on-call physician may be paged for urgent matters that cannot wait until the next business day **($40.00 Fee)**. Call 911 for any life threating emergencies.
  - **Patient Portal:** I agree to register with email and download Healow application.
  - **Etiquette:** I agree to be kind, patient, gracious, understanding and to treat the staff at Bluebonnet Pediatrics with mutual respect.

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- I agree to provide my primary and secondary insurance at **every visit** to Bluebonnet Pediatrics. Failure to provide updated insurance or report changes may result in claim denial of payment and any balances are patient responsibility.
- Payment for all services is my responsibility and is due and payable to Bluebonnet Pediatrics at the time services are rendered including copayments, deductibles, coinsurance and cost of noncovered services.
- We will make every effort to verify insurance eligibility at each visit; however, it is the responsibility of the patient/parent/guardian to determine comprehensive covered services and insurance eligibility.

- I understand that I will be responsible for all charges incurred if Bluebonnet Pediatrics is not an in-network participant or if Bluebonnet Pediatrics does not file to my insurance.
- Bluebonnet Pediatrics will submit a claim to my insurance company and I agree to assign all benefits to Bluebonnet Pediatrics.
- I understand it is my responsibility to know if my well visits are covered one per calendar year or once every 365 days.
- I understand that if there is any concern that arises during the course of a well child preventative visit that carries a diagnosis of anything besides well child, per my insurance guidelines, I will pay any additional copays, deductibles or coinsurance at the time of service.
- I understand there are some services that are not covered by insurance plans that are recommended by the American Academy of Pediatrics and are an important part of the care of my child, therefore I agree to pay for those noncovered items.
- I understand that I must notify my insurance company within 30 days of the birth of a new baby in order to secure insurance coverage for my newborn.
- I agree to request referrals and authorizations with at least 10 business days notice
- I understand that I am responsible for any balances due once insurance claims are complete.
- I agree to provide any signed and dated legal court documents for custody and medical decision making.
- I understand that I must provide Bluebonnet Pediatrics with the responsibly party for patient's insurance. In the case of separate households, the parent/guardian or authorized adult that brings the patient is responsible for the charges incurred at the time of visit.
- I understand that Bluebonnet Pediatrics does not bill third party individuals.
- I understand that my child will automatically be placed on inactive status if not seen in office within 24 months.
- I understand vaccines will be charged to patient responsibility if the vaccine is prepared and unable to be given due to staff safety or vaccine refusal.
- I understand that no video or audio recordings are allowed unless consent has been given by Dr. Garcia.