



2019/
2020

FINANCIAL POLICY

WE at Texas Children’s Pediatrics (TCP) are committed to providing you with quality care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about this financial policy.

You are personally responsible for payment at the time of service for all charges that result from care provided by TCP, including any amounts not covered by your health plan. To assist us in establishing your TCP financial account, please:

- Supply all necessary information for the accurate billing of your claim, including your insurance card, employer information and demographic information.
- Satisfy all insurance co-payments, deductibles and non-covered services on the day services are rendered.
- Provide your insurance company and TCP with any additional information requested to complete the processing of claims filed on your behalf.

UNACCOMPANIED MINORS

Minor must have an authorization for medical treatment signed by his/her parent/guardian and is responsible for providing current insurance information for self. Please note that co-payments and/or deductibles are expected at the time of service.

REGARDING DIVORCE:

TCP does not get involved in disputes between divorced parents regarding financial responsibility for their child’s medical expenses. By signing as guarantor below, you agree to be financially responsible for the care we provide to your child, regardless of whether a divorce decree or other arrangement places that obligation on your former spouse.

REGARDING HEALTH PLANS AND INSURANCE

For each visit to TCP, it is your responsibility to make sure TCP is currently under contract with your managed care plan. Verification of your coverage and benefits may be required. Often this verification requires us to share the reason for your visit with your managed care plan.

If we are not contracted with your health plan, we may require full payment at the time of service. We will supply you with a copy of your itemized statement so that you can file for reimbursement from your health plan. Should your health plan require a more detailed description of services, please have them request it in writing.

If you are referred to a specialist or decide you need a specialist, you may be required by your managed care plan to call your Primary Care Physician in order to obtain an insurance referral. It is your responsibility to obtain a referral before being seen by a specialist. If a referral is not obtained in advance, you may be held responsible for payment in full to the specialist.

ASSIGNMENT OF BENEFITS

In consideration of the services rendered or to be rendered by TCP, I hereby irrevocably assign, transfer and set over to TCP all right, title and interest in all benefits payable for the health care rendered by TCP to the patient(s), which benefits are provided in any and all insurance policies, employee benefit plans, re-insurance/stop loss contract and/or third party actions against any other person or entity, for whom my spouse, dependents or I are entitled to recover. I also hereby irrevocably assign, transfer and set over to TCP all right, title and interest in any and all claims, administrative appeals and causes of action against all insurance companies, employee benefit plans, re-insurance/stop loss carriers, third party administrators and/or other persons or entities responsible for the payment of health insurance benefits. I authorize my insurer, plan administrator, fiduciary and/or attorney to release to TCP any and all insurance policies, plan documents, summary plan descriptions, and/or settlement information upon written request of TCP or its attorneys in order to claim such medical benefits.

I authorize payment to be made directly to TCP or my treating physician.

I understand that there may be professional fees associated with the care provided by TCP billed separately by the person or organization who provided the services. In consideration of such services, I hereby irrevocably assign, transfer and set over to such persons or organizations all right, title and interest in all benefits payable for the health care rendered by TCP to the patient(s), which benefits are provided in any and all insurance policies, employee benefit plans, re-insurance/stop loss contract and/or third party actions against any other person or entity, for whom my spouse, dependents or I are entitled to recovered.

RELEASE OF INFORMATION

I agree to the release of any and all medical information, including HIV test results, and financial information necessary to process this and any future claims to my insurer or payer of health benefits, as I may designate that person or entity from time to time, for an indefinite period or until I submit a written revocation of this release. This consent to release and obtain information is valid until revoked and I may revoke this consent in writing at any time, except with regard to disclosures already made.

- As a service to our patients, TCP—or a third party with whom Texas Children’s contracts—provides courtesy appointment reminder calls/texts and possibly other important calls regarding financial obligations, healthcare related notifications such as well-check reminders and vaccine reminders, and potentially other texts containing surveys or other marketing or advertising. Such calls or texts may be placed using a prerecorded auto messaging system to the phone number provided to TCP. These messages are a free service from TCP, but your carrier may apply message and data rates. Opt-in consent is not required to receive services from Texas Children’s. Your signature on this form confirms your consent to receiving such calls/texts at the telephone number you have provided to us. At any time you can text STOP to stop receiving text messages.
- I have read and understand that I am personally responsible for payment on this account.
- **Medicaid:** I do _____ or I do not _____ currently have Medicaid Insurance.
- I acknowledge and, by signature on this form, agree that my provider may be participating in a shared savings program with my managed care plan. Information regarding any active program is available upon request.

Guarantor Signature: _____ **Date:** _____

Print Name _____ **Guarantor Date of Birth:** _____

E-mail _____ **Relationship to Patient:** _____

Patient(s) Name: _____ **Date of Birth:** _____