LONE STAR PEDIATRICS

CONSENT FOR CARE AND TREATMENT

Patient Name (Please Print): _____

I, the undersigned, do hereby agree and give my consent for Dr. Thorstad and associates to furnish medical care and treatment to my child,

_____.

_____ _____

Parent/Guardian Signature Date

FINANCIAL POLICY STATEMENT

Thank you for choosing us as your health care providers. The following statement is our financial policy. Your agreement to this policy is required prior to any treatment.

Minors

- The parent or legal guardian is responsible for payment at the time of your visit.
- For patients not accompanied by a parent or legal guardian, written permission to treat the child is required before any treatment can be given.

Please list anyone you give permission to bring your child to the office:

_____

Insurance

- Replacement Immunization Cards are $10.00.
- All co-pays and deductibles are collected at the time of service. There is a $25 charge for checks returned for insufficient funds.
- If we are not in-network for your insurance company, you are responsible for filing the claim and payment is due at time of service.
- It is your responsibility to ascertain that Dr. Thorstad is a participating provider.
- Patients that pay in full at the time of services will receive a 20% discount. You may then file a claim directly with your insurance company.
- Some insurance companies do not cover some routine and non-routine services. You are responsible to verify benefits and coverage prior to any visits so that you are not billed for unanticipated charges. Non-covered services will be billed directly to the patient. Common exclusions are well visits, some immunizations, hearing screens, vision screens and after-hours phone calls, and physician referral letters.
- All outstanding balances that have not been paid within 60 days will be billed to the patient and must be paid by 90 days, regardless of the insurance status.

Missed Appointments

We attempt to make reminder calls for well visits, but it is ultimately your responsibility to remember appointments. Cancellations require 24-hour prior notice. Cancellations with less than 24-hour notice and missed appointments will be assessed at $25. Please schedule well checks at least one month ahead.

After Hours Calls

There is a $35 charge for all after-hour doctor consultations, and a $25 charge for after-hours calls, provided by the Seton Call Center. If you like, you can also request to speak directly to the doctor after 10 p.m. These charges will be billed to your insurance company.

I have read the above Financial Policy and I understand and agree to its terms.

_____ _____

Parent/Guardian Signature Date

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

Patient Name (Please Print): _____

I, the undersigned, do hereby confirm that I have been given access to and have reviewed a copy of Lone Star Pediatrics' Notice of Privacy Practices.

_____ _____

Parent/Guardian Signature Date

☐ *I would like a copy of this statement.*

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