KILLEEN PEDIATRIC CARE CLINIC PA

4102 S CLEAR CREEK SUITE 107

KILLEEN, TX 76549 254-526-8300

Agreement Regarding Payment and Collection On Accounts

Agree that I will be responsible for all amounts that is not paid/covered by my insurance for medical services rendered by Killeen Pediatric Care Clinic. I further agree that in the event that my account is referred to a collection agency for collection of any delinquent amounts owed, I will be responsible for payment of all collection fees charged by the collection agency in addition to all amount owed to KPCC. I acknowledge that this amount is 35% of the total amount of balance due. I further agree that in the event that a suit is instituted to but not limited to court costs and attorney fees. (Most insurance carriers allow one physical per year after the age of two, if you see another physician for a physical and then come to this clinic and your insurance has already paid for a physical for that year you will be responsible for the charges incurred.)

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Signature of Parent or Legal Guardian Date

Agreement Regarding Release of Medical Records

I understand that there is a charge for release of medical records. This charge is $25.00 for the first twenty pages and .15 cents for each additional page. I understand that I will have to pay this charge if I request that the medical records be released. I understand that the only exception to this is if there is an emergency situation. I further understand that immunization records will be released free of charge one time. Each additional copy will cost $5.00. Additional charges for forms filled out by doctor will also be $7.00 first page per form $2.00 each additional page EFMP charge will be $20.00. All charges are due at time of request.

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Signature of Parent or Legal Guardian Date

Agreement Regarding No Shows

I understand that if I no show for two consecutive times at this practice without prior cancellation of my appointment, that I may be discharged from this practice. I understand time is very valuable in a physician's office and that appointments are limited. I understand that if I do not make my appointment, I will be responsible for a payment of $25.00. This is an out of pocket expense and is not covered by insurance. Failure to show up for your appointment is disallowing other patients the time slot.

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Signature of Parent or Legal Guardian Date

Acknowledgement of HIPAA

I acknowledge that the HIPAA policies are posted and I have read and agreed to these policies.

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Signature of Parent or Legal Guardian Date