Heights Pediatrics
100 W Central Texas Expressway Suite 110
Harker Heights, TX 76548 254-213-4052

Agreement Regarding Payment and Collection on Accounts

I agree that I will be responsible for all amounts that are not paid/covered by my insurance for medical services rendered by Killeen Pediatric Care Clinic. I further agree that in the even that my account is referred to a collection agency for collection of any delinquent amount owed, I will be responsible for payment of all collection fees charged by the collection agency in addition to the full amount owed to KPCC. I acknowledge that this amount is 35% of the total balance due. I further agree that In the event that a suit is filed that I may be responsible for but not limited to court costs and attorney fees as well. (Most insurance carriers allow one physical per year after the age of 2, if you see another physician for a physical and then come to this clinic and your insurance has already paid for a physical that year, you will be responsible for the charges incurred.)

_____ _____

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 $0.15 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 an emergency situation arises. I further understand that immunizations will be released free of charge one time only and that additional copies will cost $5.00 each. Any forms that need to be filled out by the doctor will incur an additional charge of $7.00 for the first page per form and $2.00 for each additional page, EFMP charge will be $20.00. All charges are due at time of request. '

_____ _____

Signature of Parent or Legal Guardian **Date**

Agreement Regarding No Shows

I understand that if I no show two consecutive times without prior cancellation of my appointment, that I may he discharged from this practice. I understand that 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.

_____ _____

Signature of Parent or Legal Guardian **Date**

Acknowledgement of HIPAA

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

_____ _____

Signature of Parent or Legal Guardian **Date**