

Village Pediatrics Waco PLLC  
4515 Lake Shore Dr.  
Waco, Texas 76710

www.villagepediatricswaco.com  
Tel. 254-269-3099  
Fax 877-569-2842



Date: \_\_\_\_\_

**Patient Information**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Sex: \_\_\_\_\_  
Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_  
Address: \_\_\_\_\_ Apt. # \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**Additional Information**

Email: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

Cell: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ Other: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Employer Phone: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_

Relation to Patient: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Patient's Marital Status:

Single \_\_\_\_ Married \_\_\_\_ Separated \_\_\_\_ Divorced \_\_\_\_ Widowed \_\_\_\_

PATIENT'S:

Spouse's Name: \_\_\_\_\_

Spouse's Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Insurance Information**

**Primary Insurance**

Company: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Policyholder: \_\_\_\_\_

**Secondary Insurance**

Company: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Policyholder: \_\_\_\_\_



**CONSENT TO TREAT – Please read carefully**

**Patient Name:** \_\_\_\_\_

**DOB:** \_\_\_\_\_

**CONSENT FOR TREATMENT**

I hereby authorized evaluation and treatment by the physicians and staff associated with Village Pediatrics Waco, PLLC. I understand and agree that the signatures and dates on this form will not expire without written notice or in the case that a minor becomes the age of 18, and that a photocopy of this form is considered valid as the original.

\_\_\_\_\_  
Patient (Please Print)

\_\_\_\_\_  
Parent (Signature) or patient if over the age of 18

\_\_\_\_\_  
Date

**CONSENT TO RELEASE INFORMATION TO ANOTHER ADULT  
(Over the age of 18)- Please Read Carefully**

I hereby authorize \_\_\_\_\_ to receive information on my  
Name/Relationship

behalf if I am unable to be reached. I understand that any medical advice will be relayed to them on my behalf. I understand and agree that the signatures and dates on this form will not expire without written notice and that a photocopy of this form is considered valid as the original.

\_\_\_\_\_  
Parent Name (Please Print)

\_\_\_\_\_  
Parent (Signature)

\_\_\_\_\_  
Date



## **Village Pediatrics Waco, PLLC**

### **FINANCIAL POLICY– Please Read Carefully**

- Copayment, deductible or coinsurance is due at the time of service. We accept Cash, MasterCard or Visa.
- Any balances that are applied to your deductible must be paid in full before the next office visit.
- **WE DO NOT ACCEPT CHECKS.**
- **24 hour prior notice of appointment cancellation is required.** A **\$25.00** cancellation fee will apply after the second cancellation that does not meet our requirements. A **\$50.00** cancellation fee will apply after the third cancellation that does not meet our requirements. A **\$50.00** cancellation fee will be charged for consults.
- Billing statements are sent out each month. Any balance not covered by your insurance must be paid in full before the next appointment. Unpaid balances over 90 days may be turned into collections, and additional fees will be assessed.
- For private pay families, we offer a cash rate discount. Please contact our office for cash rates. **All balances must be paid in full at the time of the service. Please note: NO CHECKS ACCEPTED.**
- **A \$25.00 charge for medical records must be paid at the time the records are requested from Village Pediatrics Waco, PLLC.**

**Please note:** There will be a charge for after-hours calls. The charge will be **\$25.00 billed directly to the patient**. This fee is not covered by any insurance plan.

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Patient Name (Please Print)

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Date

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Patient Name (Signature)

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Date



### **Village Pediatrics Waco, PLLC**

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#### **INSURANCE AUTHORIZATION – Please read carefully**

##### **INSURANCE INFORMATION**

- As a courtesy to our patients we have enrolled in many managed care programs. However, we do not take responsibility for items that are not covered by your individual plan.
- We will not file any claims for patients without an insurance card. You can request your insurance company to fax or provide you with insurance documentation of coverage that includes all billing information.
- We will not be responsible for any denied claims due to filing deadlines if new insurance is not presented to us at the time of service. Check which lab your insurance company is contracted with.
- Prior to the office appointment, please be sure that you have contacted your insurance company to add your new baby/child to the insurance policy. If the claim is denied, you will be responsible for payment.
- It is advised that all patients verify (if not already known) to see if we are a network provider for your insurance.
- Our clinic holds an additional stock of state mandated immunizations available for your child free of charge if you meet the criteria of being underinsured. A \$13.00 charge per vaccine administration will apply.

##### **AUTHORIZATION**

As a courtesy, Village Pediatrics Waco, LLC will verify and file insurance, but the practice cannot guarantee payment. I understand that I am financially responsible for services rendered as and when charges are incurred. I hereby authorize Village Pediatrics Waco, LLC and/or the rendering physicians(s) to release all medical information required by my insurance company to file claims for medical benefits. I authorize payment of all applicable benefits directly to Village Pediatrics Waco, PLLC. This authorization will remain in effect until revoked by me in writing. A photocopy is to be considered as valid as the original. Consent to release information acquired in the course of examination and/or treatment in regards to treatment, payment of services and operations is understood and explained to me in the posted Notice of Privacy Practices.

Patient Name (Please Print)

Parent Signature

Date

.It excludes disclosures we may have made to you if you authorized us to make the disclosure, for a facility directory, to family members or friends involved in your care, or for notification purposes, for national security or intelligence, to law enforcement (as provided in the privacy rule) or correctional facilities, as part of a limited data set disclosure. You have the right to receive specific information regarding these disclosures that occur after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limitations.

**You have the right to obtain a paper copy of this notice from us**, upon request, even if you have agreed to accept this notice electronically.

### **3. COMPLAINTS**

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint. You may contact our Privacy Officer, Catherine Paige Price, FNP at (254) 269-3099 or [admin@villagepediatricswaco.com](mailto:admin@villagepediatricswaco.com) for further information about the complaint process.

This notice was published and becomes effective on January 6, 2025. If you wish to have a copy of this document for your records, please ask the front desk staff to print you a copy. You may also download a PDF version of this document from our web site:  
[www.villagepediatricswaco.com](http://www.villagepediatricswaco.com)

**I hereby acknowledge the receipt of “Village Pediatrics Waco, PLLC Notice of Privacy Practices, Version I” and agree to the terms and conditions stated in this document:**

***This is the only the last page of the Notice of Privacy Practices. If you would like to have a copy of all pages, please let us know or visit our website.***

Date of Birth: \_\_\_\_\_

\_\_\_\_\_  
Patient's Name (Please Print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date