julietomberlinMD
pediatric and adolescent medicine
706 hunters row ct . mansfield . texas . 76063 . 682-518-8111o . 682-518-8112f

Office Hours:

We are open Monday-Friday 8:30am-5:00pm. We are closed on major holidays and may have closures on other days around the holidays, which will be announced.

Appointments:

- ***All office visits are by appointment ONLY.***
- ***We charge for no show appointments, late arrivals, and less than 24-hour cancellations.***
- ***Please notify us if you cannot keep your appointment.***

Phone Calls:

- We will make every effort to return your call as soon as possible. Every call is screened by a nurse and prioritized by matter of urgency. Please notify the receptionist if the matter is urgent.
- Our phones are transferred to an answering service after business hours. You may contact Children's Medical Center Nurse Advice Line at 1-855-456-6976. There is no charge for this service.

Prescription Refills:

All refill requests must be made during office hours. Please give at least 3 business days for refills to be completed.

Billing:

We will bill the insurance companies with whom we are contracted. Payment is expected at the time of service for any copays and deductibles not covered by your plan. We accept cash, check, and credit cards (Visa, Master Card, and Discover). There is a $50 charge for returned checks.

Medical Forms:

We will need 3 business days to complete all medical forms, including but not limited to all daycare, school, physical, and medication administration forms. There is a fee for completing all forms.

Patient Information:

Please keep us updated on any address or phone number changes. Please have current insurance card with you at each visit.

We strive to provide the best care for our patients and their families. We look forward to taking care of all your health care needs.

Sincerely,
Julie Tomberlin, M.D. and staff
Questions?
682-518-8111

FINANCIAL POLICY and PATIENT CONSENT FORM
DATE: _____ / _____ / _____

The following is provided to avoid any misunderstanding concerning payment for medical services.

1. **PAYMENT**:
    a. Payment is expected at the time of service.
    b. You are responsible for any balance after insurance processes your claim.
    c. Any balance remaining after insurance processes the claim is billed to the responsible party indicated on the account. Accounts not paid in full after 90 days will be referred to an outside collection agency or paid using Credit Card on File information.

2. **MANAGED CARE**:
    a. All managed care (HMO, PPO, etc.) co-payment amounts are due at the time of service.
    b. This office does not set copayment amounts.
    c. This office collects $100 per visit for ALL plans with deductibles that apply to medical office visits. This is an ESTIMATE of the cost of the visit. Any balance will be billed and any overpayment will be credited to the account once the claim has been processed.

3. **CHILDREN OF DIVORCED PARENTS**:
    a. The parent or guardian who brings the child for any visits is the responsible party.
    b. Responsibility for payment for treatment of minor children whose parents are divorced rests with the parent who is in our office building at the time of treatment.
    c. This parent is required to pay for services rendered regardless of what a divorce decree may state. Any court ordered responsibility judgment must be determined between the individuals involved, without the inclusion of JTMD PA.

4. **RETURNED CHECKS**: There will be a $50 charge for returned checks.

It is our hope that the above policies will allow us to provide the highest quality care to our patients. If you have any questions or need clarification regarding these policies, please call us at (682) 518-8111.

_____ _____
Patient Name (Please Print) Patient Date of Birth

_____ _____
Signature (Insured/Guardian) Date

_____
Printed Name (Insured/Guardian)

Billing Summary / Benefits Policy

PATIENT:
LAST NAME_____

FIRST NAME_____

MIDDLE INITIAL_____

Our office will accept an assignment of benefits from your insurance company with the following provisions:

1. Filing claims through insurance does not eliminate the financial obligation for the medical service my child or I have received.

2. Copay, deductible and coinsurance amounts are due in full at the time of service. We do not waive collection of these fees in exchange for medical services. Payment of any remaining balance is due after your insurance company processes the claim or as provided below.

3. If we have not received payment after 90 days, we will charge the credit card we have on file OR we will forward the balance to a third-party collection agency.

4. **If your claim is denied, you will be responsible for paying the self-pay or cash balance plus full cost of all medical supplies.**

5. Our office will NOT enter into a dispute with your insurance company for any claim, although we will provide necessary documentation your insurance company requests to sort out any confusion or questions that may arise. We will cooperate fully with the regulations and requests of your insurance company. It is ultimately your responsibility to resolve any type of dispute over payments made or not made by your insurance company.

I HAVE READ AND UNDERSTAND THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY HEALTH BENEFITS DIRECTLY TO THE OFFICE OF JULIE TOMBERLIN MD PA.

_____
AUTHORIZED SIGNATURE

_____
Printed Name

_____
DATE

Confidential Communication Request (HIPPA Form)
DATE: _____ / _____ / _____

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PATIENT:
LAST NAME_____ DATE OF BIRTH: _____ / _____ / _____

FIRST NAME_____

MIDDLE INITIAL_____

In order to protect your child's privacy, we need your written permission to leave detailed phone, email or text messages regarding your child, including messages that contain health and/or billing information. Please note that current Notice of Privacy Practices allows us to contact you without written approval with a courtesy reminder regarding upcoming appointments.

PLEASE INDICATE YOUR AGREEMENT BY MARKING ALL THAT APPLY. LEAVE BLANK ANY FOR WHICH YOU DO NOT GIVE CONSENT.

☐ Detailed phone messages regarding my child may be left on the following numbers:

☐ Phone 1 _____ Initials _____

☐ Phone 2 _____ Initials _____

☐ Detailed text messages regarding my child maybe be sent to the following numbers:

☐ Phone 1 _____ Initials _____

☐ Phone 2 _____ Initials _____

☐ Detailed emails regarding my child may be sent to the following email address. I understand that Julie Tomberlin MD, PA does not use a secure email system and that any message sent via email is not secure.

☐ Email _____ Initials _____

☐ I give permission for Julie Tomberlin MD, PA to give detailed information regarding my child to the following:

_____

Name Relationship Phone

_____

Name Relationship Phone

THE ABOVE PERMISSION WILL REMAIN IN EFFECT UNTIL RESCINDED IN WRITING.

_____

Signature Printed Name

LATE, CANCELLATION and NO SHOW POLICY

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DATE: _____ / _____ / _____

LATE

We will no longer see patients who arrive after their scheduled appointment time. In order to keep the appointments as on-time as possible, late arrival to an appointment will cause you to be rescheduled and charged a $25 fee

NO SHOW

No show appointments will be charged $50 for each missed sick appointment and $100 for each missed well check appointment. Your child(ren) will be dismissed after the 3rd missed appointment for your family. We will not see new patients who no show their first appointment.

CANCELLATIONS

A $25 fee will be charged to each appointment that is cancelled within 24 hours of the appointment.

*****Automated appointment reminders are a courtesy only and should be relied upon for keeping your child's appointment.**

Signature of Parent/Guardian: _____

Printed Name of Parent / Guardian: _____

Printed Name of Patient: _____

Date: _____