Pediatric Associates of Austin 1500 W. 38th Street, Suite 20, Austin, TX 78731
Telephone: 512-458-5323 Fax: 512-458-2030

Value-Added Services Agreement

I want to maintain a relationship with my pediatrician's office and understand that in order to prevent services from being reduced or eliminated, an annual value-added service fee will be charged. I agree and accept the annual fee for these value-added services. These services are not covered or required under my managed care plan.

- Medical care is provided by Board Certified Pediatricians
- All office treatments, vaccines and other injectables are administered by pediatric nurses.
- Common in-house lab and x-ray is available for your convenience with "while you wait" results.
- Finger stick technology is used whenever possible. Outside labs, such as Clinical Pathology Labs, collect blood by venipuncture (out of the arm) rather than the finger stick.
- When special lab tests are required that are outside the scope of in-office lab services, we will do the blood collection *for you and send it out* rather than having you travel to Clinical Pathology for collection.
- Our own pediatric nurses are available during regular business hours for advice *at no extra charge* and available after hours for a nominal fee. The on-call physician supports the nurses.
- Urgent care appointments are available weekend mornings.

The annual fee for these services is:

	Fee	Discounted if paid by 4-1-10
1 Child	$115.00	$103.50
2 Children	$220.00	$198.00
3 or More Children	$250.00	$225.00

Please note: (A prorated rate will apply for new patients after 2/28/10. As a new patient to the practice, we want you to be certain that you will be 100% satisfied with the benefit of our value-added services. If you decide, within your first year, to transfer your records to another practice physician, we will cheerfully refund your money.)

Please list your child/children below; using the back for any additional children.

_____ __/___/____ _____ __/___/____
Name DOB Name DOB

_____ __/___/____ _____ __/___/____
Name DOB Name DOB

Enclosed is my payment of $_____

Credit Card #_____Exp. ___/___/____ Visa, MasterCard, Discover

_____ _____ _____
Printed Name Signature Date

Please include your email address below if you wish to receive a **credit card** receipt via email.

_____

* If you choose to decline, Pediatric Associates will forward a copy of your child's medical record to their new physician upon your written request. **You will always be welcomed back to Pediatric Associates should your situation change at a later date.**