TELEPHONE PROTOCOL

We offer an after-hours triage service that is provided by a third-party. We are required to offer this service to you 24/7. **However,** this service creates a significant operational cost for the practice and we are surcharged for every call that is made. This is why we MUST charge you a $35 per-call fee. Please note that this third-party does not have access to any of your children's chart information or medical history. Every-time you select Option 7 and/or Option 8 in the phone system you will be transferred to this service and billed $35.

If you would like a call back from a member of our staff please use one of the following options:

Option 1-2: Front Desk - No medical advice
Option 3-5: Medical Staff - Please use this option for medical advice
Option 9: Menu Tree in Spanish
Option 0: Operator - Ask to be transferred or to reach voicemail

Most insurance companies offer their own service for **FREE**. The phone number can be found on the back of your insurance card.

If your insurance company does not offer this service, you may call the Medical Advice Line at Dell Children's Medical Center of Central Texas at 512-324-9999 ext 12459.

Please sign the next line to acknowledge the statement above.

Parent Signature Date

EMAIL CONSENT

Due to recent changes to HIPAA we are now able to send protected health information (PHI) by unencrypted email. By signing below you are consenting to allow us to send sensitive information to you via email such as vaccine records, invoices, etc. The disadvantage to unencrypted email is that it is very much like writing the same information on a post-card and mailing it -- everytime it changes hands, the person (or server) can read it. We do offer a secure, HIPAA compliant email subscription for $60.00 per year.

If you do not consent to communicating by email, your account will be billed $6.00 for every piece of mail we send to you. Most of the time, what we mail is billing related. If you do not want to consent to emailed invoices and still want to avoid the $6.00 postal fee, you may leave a valid credit card on file with sufficient funds to cover your medical expenses. Please see our Financial Policy for more details.

Please **Check One** of the following:

▢ I consent to unsecure email communications. My email address is: _____

▢ I do not consent to unsecure email communications

Please sign the next line to acknowledge the statement above.

Parent Signature Date