FINANCIAL POLICY & ASSIGNMENT OF INSURANCE BENEFITS

Valley Children's MEDICAL GROUP

Patient Name: _____ DOB: _____

Please list the types of insurance coverage which you have and provide the receptionist with your insurance cards.

	Primary	Secondary
Company		
Subscriber Name		
Subscriber DOB		
Subscriber SSN		
Policy or ID #		
Group #		
Relationship to Patient	☐ Mother ☐ Father ☐ Step-Parent ☐ Guardian	

ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION

- I hereby authorize payment directly to Valley Children's Medical Group of any medical/surgical benefits payable to me under the conditions of my policy for services rendered.
- I hereby consent to the release of the above-named patient's financial and medical information concerning care, treatment and charges for the purpose of completing all claims for benefits.

FINANCIAL POLICY

1. Each patient is responsible for his/her own bill. The required co-payment must be paid at the time of service.
2. As a courtesy, the office will submit claims to your insurance carriers. It is the insured's responsibility to provide current information regarding any changes with insurance carriers.
3. It is the insured's responsibility to pursue slow payment or non-payment on the part of his/her insurance company directly regarding the claim. We will be happy to assist you with any collection problems; however, the bill remains the full responsibility of the patient.
4. The following fees may be applied:
   - $15.00 service charge for all returned checks
   - $20.00 NO SHOW fee may be charged for failure to cancel an appointment at least 24 hours in advance
   - $25.00 Form fees for FMLA, medical records and other miscellaneous forms
   - $25.00 fee may apply for preparation of medical records
5. Payment arrangements must have a minimum monthly payment of $25 and must be paid within one year. Account becomes delinquent after 60 days of no activity and may be sent to collections after 90 days.
6. Patients will receive a monthly statement only when there is a balance due. Charges which have not been paid by insurance will be transferred to patient responsibility for which you will receive a statement. All patient due balances are expected to be paid within 30 days of receipt of the statement.
7. For those patients participating in a managed care plan, it is your responsibility to inform the doctor regarding limitations on referrals for service outside our facility during each visit. Valley Children's Medical Group will not be held responsible for charges on service incurred for any referral.
8. If at any time you cannot comply with policies indicated above, arrangements must be made in advance. Requests for alternative plans of payment will be reviewed and effort will be made to come to an agreeable arrangement.

The undersigned acknowledges and agrees that he/she is financially responsible to Valley Children's Medical Group for the services rendered. In the event of a collections action, the undersigned agrees and acknowledges that he/she shall be responsible for any legal fees incurred. I have read the above policy and agree to comply with its provisions.

_____ _____ _____

Signature of Parent/Responsible Party Print Name Date