CONSENT FOR PAYMENT AND HEALTHCARE OPERATIONS

I have read the Children's Program Financial Policy and am aware of my financial responsibility on behalf of:
CLIENT____DOB:____________

I understand I am financially responsible for all charges. Payment is due in full on the day of service. If the Children's Program agrees to bill insurance, I will pay co-payments, co-insurance or deductibles as required at each visit. I understand billing insurance is not a guarantee of payment. If insurance denies coverage for a service or procedure, I am responsible for these charges.

A billing charge will be assessed on balances after 60 days. Accounts must be paid in full within 90 days. A CREDIT CARD NUMBER MUST BE ON FILE IF WE ARE BILLING INSURANCE. Charges remaining after 90 days may be charged to avoid further finance or collection fees. The Children's Program will attempt to reach me prior to authorizing the charge. My (please circle) Visa Mastercard Discover

Card# ____Exp ________________________

- If the Children's Program is billing the health insurance carrier, I request payments be made directly to the Children's Program. If the insurance carrier sends a payment to the patient/family member, I will forward that payment to the Children's Program for credit to my account. **The Children's Program may disclose the information necessary to process my insurance claims to any person, corporation, or agency responsible for payment including: ______insurance carrier ______school ______other (specify)**
- I acknowledge that the patient does not hold Oregon Health Plan Insurance (DMAP). If the patient unknowingly has DMAP insurance, as either primary or secondary insurance, I waive the right to have DMAP billed. I agree to pay per the Children's Program fee schedule, including fees for missed appointments.
- In cases of divorce, the parent/guardian initiating service is responsible for the account and must sign this form. If that parent does not carry the client's health insurance, this form must also be signed by the individual who carries the insurance in order to submit a claim and have the benefits assigned to our office.
- I understand that I must call **DURING OFFICE HOURS** and give at least 24 business hours advance notice when canceling an appointment. If I fail to do so, I understand I will be charged for the missed appointment.
- If I am receiving services under a managed care mental health insurance contract, I understand that my policy limits the coverage/services I can receive. I understand I may be required to obtain preauthorization before scheduling appointments. The health insurance carrier may limit the number of appointments I can schedule or the time period in which appointments may occur. My health insurance may limit the types of procedures or diagnoses for which treatment is provided. I agree to be financially responsible for appointments that are not covered by health insurance because of breech of any of these conditions. The managed care company may require a release of information about treatment to the primary care physician.
- If I choose to submit claims for services deemed outside Children's Program insurance billing policies, I am aware that Children's Program will not accept assignment/provider discounts.
- I understand I must notify the Children's Program of any changes in my health insurance coverage prior to the next appointment. I understand the Children's Program will not retroactively bill for changes if insurance carrier.

In the event of nonpayment of charges, the Children's Program shall be entitled to disclose information and recover all costs and expenses incurred in seeking collection of such charges including, without limitations, court costs and reasonable attorney's fees, whether such claims are pursued through court proceedings, appellate or bankruptcy proceedings, arbitration, or mediation.

I have read and authorized the above. Signed:

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Financially Responsible Party Date Relationship to client

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Insured Party (if different from above) Date Relationship to client