CONSENT FOR HEALTHCARE OPERATIONS

CLIENT_____**DOB:**_____

I understand I am financially responsible for all charges. Fees are payable on the day of service. The amount owed will be charged to the credit card on file as required in the Child Information Form. If the Children's Program agrees to bill insurance, I will pay co-payments, co-insurance or deductibles as required at each visit. My primary, and in some cases, secondary insurance will be billed. I understand billing insurance is not a guarantee of payment. If my insurance denies coverage for services or procedures, I am responsible for the charges. Accounts must be paid in full within 90 days. Balances remaining after 60 days will accrue billing charges. Charges remaining after 90 days will be charged to the authorized credit card on file to avoid further billing or collection fees.

- I request health insurance payments be made directly to Children's Program. If the insurance carrier sends payment to the patient/family member, I will forward 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 carriers ☐ school ☐ other (specify)**

- I acknowledge that the patient does not hold Oregon Health Plan Insurance (OHP). If the patient unknowingly has OHP insurance, as either primary or secondary insurance, I waive the right to have OHP billed.

- 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 **48 business hours advance notice when canceling** an appointment. If I fail to do so, I understand I will be charged up to 100% of the appointment fee. Evaluation appointments require a one-week notice. We may elect not to reschedule evaluations cancelled without sufficient notice.

- If I am receiving services under a managed care mental health insurance contract, 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.

- I understand that insurance benefits for Speech and Language services vary greatly. I am aware that it is my responsibility to understand these insurance benefits before visits occur. Children's Program cannot guarantee services will be covered/paid for by your plan.

- If I choose to submit claims for services 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.

Patient care coordination standards strongly recommend the practice of sharing information with the patient's PRIMARY CARE PROVIDER. I consent to the Children's Program exchanging information as appropriate.

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Name of Primary Care Provider (Pediatrician) **Group Affiliation if Applicable**

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Office Address

I have read and authorized the above.

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Financially Responsible Party/Legal Guardian Date Relationship to client