CHILDREN'S CLINIC CONDITIONS OF SERVICE FORM

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Patient MRN

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Date

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Employee Initials

Please Initial the Following:

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1. **If your insurance requires a copayment**, it is due at check-in, prior to seeing the doctor. Copayments are a contract between you and your insurance company.

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2. **When you present a current eligibility certificate** and/or insurance card, the Children's Clinic will file your insurance claim. It is your responsibility to contact your insurance company with questions concerning the status of outstanding claims.

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3. **Assignment of Benefits and Promise of Payment**: I authorize my insurance company or health plan to pay medical benefits on my behalf directly to the Children's Clinic. I understand and agree that I remain financially responsible for the payment of all medical services provided by the Children's Clinic. If the Children's Clinic is not a participating provider with my health plan, I understand and agree that the Children's Clinic may choose not to bill my health plan and that I will be billed for all services. I authorize the Children's Clinic to use or disclose my healthcare information to assist in obtaining reimbursement for services rendered. A Patient Accounts Specialist is available to discuss payment arrangements or one of our financial programs including financial assistance. If I default or do not pay my bill, I understand that my account will be turned over to a collection agency.

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4. **The Children's Clinic appreciates payment in full within thirty (30) days from invoice date.** However, if it is not possible to make payment in full, it is your responsibility to set up a payment plan by notifying a receptionist or the clinic's Patient Accounts Specialist. Please note that financial assistance is available based on financial need. If you would like to request financial assistance, please contact our Patient Accounts Specialist for more information. You will receive a monthly statement of your account. A payment against the unpaid balance is due upon receipt of the statement; any overpayment will be refunded. There is a $29.00 fee on all not-sufficient-funds checks returned to the clinic.

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5. **Appointment of The Children's Clinic as Authorized Representative**: I understand the Children's Clinic may assist in pursuing a claim or appeal of a denied claim. I authorize and appoint the Children's Clinic to act on my behalf and/or on behalf of my covered child/dependent (under 18 years of age) as my authorized representative with any insurance carrier with whom valid insurance coverage exists for medical services. I further direct that any payment made by any insurance carrier as a result of a successful appeal is to be paid directly to the Children's Clinic. This authorization and appointment will remain valid until such time as I revoke this authorization and appointment in writing to the Children's Clinic and my insurance carrier(s).

I have read and understand the above policy. I understand I can request a copy of this agreement for my records as the Responsible Party on the account.

Signature of Patient or
Authorized Party ____ Date __________________________

Relationship to Patient _______________________________________

The Children's Clinic of Billings, PC complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.