The Children's Clinic of Klamath Financial Policy

We are committed to providing you with the best care possible. This goal is best achieved if everyone is aware of our policies. Your clear understanding of our financial policy is important to our professional relationship.

INSURANCE:

Payment for services is due at the time services are rendered, except as outlined below. Insurance plans vary considerably, and we cannot predict or guarantee what part of our services will or will not be covered. It is the responsibility of the patient to provide **ACCURATE** and **TIMELY** insurance information. Inaccurate or untimely information given to the staff that results in denial or non-coverage by your insurance company will result in the guarantor/patient being responsible for payment. All patient balance questions should be made directly to your insurance for an explanation of benefits.

NON-EMERGENCY APPOINTMENTS:

Well visits, physicals, any non-emergent follow ups and visits may be rescheduled if there are outstanding balances or co-pay is not paid at time of service. If you are experiencing financial difficulty, please let us know. Health insurance is a contract between you, your employer and your insurance company. It is important for you to be an informed consumer who understands the specifications of your insurance policy (including vaccine and doctor visit coverage, referral/authorization requirements for specialty care, x-rays, lab tests, emergency hospital care, ect.).

BILLING:

We accept cash, checks, American Express, Discover, MC or Visa. Co-pays are due at the time of service. Deductibles and any patient responsible balances will be billed to the patient. Outstanding balances are due within 30 days of the statement date, unless prior arrangements have been made with the office. Balances not paid within the 30 days of the first statement date may be subjected to cancellation of your next appointment. Balances not paid in full within 90 days of the initial statement date will be forwarded to a collection agency. If your account is sent to collections a second time, your family will be dismissed from our practice.

A $35.00 fee will be charged for all returned checks and your account will be placed on a "cash or credit card basis only." We will accept payments by cash or credit card only until the balance is cleared.

For any children seen, the accompanying parent or adult is responsible for full payment at the time of service. In case of divorce, please do not place our office in the middle of marital/custodial disputes. It is your responsibility to work out the payment of your child's medical care between the custodial and non-custodial parent.

We realize tbat temporary financial problems may affect timely payment of your account. If such problems arise, we encourage you to contact our billing office promptly at 541-882-1540 for payment arrangements and assistance in the management of your account.

Should your account balance become un-collectible due to bankruptcy, you could possibly be discharged from the practice.

IF WE DO PARTICIPATE WITH YOUR INSURANCE COMPANY:

All services performed in our office and at the hospital will be submitted as a courtesy to your insurance. All co-pays are due at time of service. Deductibles and coinsurance are your responsibility and will be billed to you by our office. Not all services provided by this office are a covered benefit with all insurance plans. You may be asked to sign a waiver that you understand this and may be responsible for the costs.

IF WE DO NOT PARTICIPATE WITH YOUR INSURANCE COMPANY:

We are not able to bill your insurance and we cannot accept payment from them for the services performed. We will provide you with an itemized bill so that you may submit the charges to your insurance company for reimbursement. ***Be prepared that you will not always be reimbursed the full price amount you paid for your services by our physician. We will not reimburse you the difference between the reimbursement rate your insurance pays you and our fee for our services. Payment for services is due at the time of service.

MISSED APPOINTMENT/LATE CANCELLATIONS:

Missed appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. We reserve the right to charge a $50.00 fee for any missed appointments. We request that you cancel any appointments at least 24 hours in advance of your appointment time. We understand that emergencies happen, please reach out to us as soon as possible regarding your missed appointment. After three missed appointments without notification, our office may discharge you from the practice.

ASSIGNMENT AND RELEASE:

I hereby authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for non-covered services. I also authorize the physician to release information required in the processing of insurance claims.

I HAVE READ AND FULLY UNDERSTAND THE FINANCIAL POLICY SET FORTH BY THE CHILDREN'S CLINIC OF KLAMATH. I AGREE THAT IF IT BECOMES NECESSARY TO FORWARD MY ACCOUNT TO A COLLECTION AGENCY, MY FAMILY MAY BE DISCHARGED FROM THE PRACTICE. I UNDERSTAND AND AGREE THAT THE TERMS OF THIS FINANCIAL POLICY MAY BE AMENDED BY THE PRACTICE AT ANY TIME WITHOUT PRIOR NOTIFICATION TO THE PATIENT/GUARANTOR.

Signature of Patient/ Responsible person:_____

Print name:_____

Date:_____