



Eastside Children's Clinic

Financial Policy

Copayments, coinsurance and deductible payments are due at the time of service. **There may be an additional balance due after your insurance payments are applied to your account.** Please remember that your insurance policy is a contract between you and your insurance company. We are not a party to that contract. All outstanding balances greater than 90 days old will be turned over to a collection agency unless prior arrangements have been made with this office. You agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 25 % of the debt, and all costs, and expenses, including reasonable attorneys' fees, we incur in such collection efforts. We have implemented a policy which enables you to maintain your credit card information securely on file with Eastside Children's Clinic, PLLC. In providing us with your credit card information, you are giving Eastside Children's Clinic, PLLC permissions to automatically charge your credit card on file for co-pay for any person you have listed on these forms. If your insurance provider has paid their portion of your bill or for any other person listed and there is a balance owed, Eastside Children's Clinic, PLLC will notify you via phone/mail. If by the final billing notice/90 days, we do not receive a response from you on payment, any balance owed will be charged to your credit card. A copy of the charge will be sent by mail to you. This in no way compromises your ability to dispute a charge or question your insurance company's determination of payment.

(Families with basic medicaid are exempt from this policy)

Self-Pay

Patient(s) that **do not** have insurance will be considered Self Pay patients. Please note that the Self Pay visit cost may not be the only cost you have during your visit. If additional test and/or shots are given, you will be charged for these at checkout. So please make sure you ask the staff first, if any additional test/shots are covered. I understand that this authorization will be valid through the expiration of my credit card, unless I cancel this authorization via written notice.

HIPAA Release of Information Agreement

This office may use and disclose medical and financial information related to your care that may be necessary now or in the future to facilitate payment by third parties for services rendered by us, or to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance, or medical outcomes evaluation purposes. Records may be delivered to any physician that is directly or indirectly responsible for your medical care. We are legally obligated due to compliance with HIPAA, to maintain the privacy of your protected health information and to provide you with this Notice of Privacy Practices and to abide by its terms. We reserve the right to change our privacy practices and apply revised privacy practices to protected health information. You may speak with the Office Staff to obtain additional information regarding questions you may have concerning this Notice or to receive a printed copy of the Notice.

Treatment Consent

I agree to allow my child to receive medical care at Eastside Children's Clinic. This consent applies to routine medical care including, but not limited to, physical exams, routine testing office treatments, standard vaccinations and Telehealth visits. I understand that no interventions or treatment will be performed without first discussing with a parent / guardian.

Parent Signature: _____

Date: _____