CACTUS CHILDREN'S CLINIC, P.C.

INFORMED CONSENT

I understand that it is my responsibility to keep the office informed of any changes in my health insurance coverage, address changes or phone number changes.

I also understand it is my responsibility to report any and all insurance coverage I might have. If you are on a State aided program such as AHCCCS, you are required to provide that information at the time of service whether you have a private primary insurance or not. I also understand that if I fail to report a primary insurance to the office for billing and my claims are denied I will be held responsible for the entire balance of the claim denied. If a balance is not paid I understand that I will be responsible for any and all collection fees, attorney fees and finance charges incurred as a result of not reporting the above information in a timely manner.

I hereby declare that I have provided the office with correct and current insurance information and have not withheld any information necessary for billing claims.

I understand there is a no show fee of $25.00 charged to me that is **NOT** billable to my insurance company and will be my responsibility if I do not call to cancel my appointment **1 hour prior** to the appointment time. I understand that if my family jointly as 4 no shows in a year my family will be discharged from the practice.

Patient Name:_____ Date of Birth:_____

_____ Date:_____

Parent/Legal Guardian Signature