Financial Policy Patient
Financial Agreement

Patient Name: (Print)________________________________DOB______________________

El Paso Kids Klinic is committed to serving our patients with professionalism and care, and from our patients we expect the same commitment. This includes being on time for your appointment and calling to cancel an appointment if you can't make it. It also includes presenting your identification card and insurance cards at EVERY appointment and making your copay or deductible payments at the time of your office visit with cash or credit card.

Your responsibility is to provide us with accurate and complete information concerning your current address and phone number. As a courtesy, El Paso Kids Klinic will bill your primary insurance and your secondary insurance for you.

For services outside of our clinic, like radiology, laboratory, surgery centers, physical therapy, hospitals and rehabilitation centers, it is your responsibility to know which facility you are required to use. If you aren't sure, please talk to your insurance member services..

For All Insurances patients: Parent/Guardian Signature – I authorize payment to be made on my behalf to Huma Y. Lodhi, MD, PA (d.b.a El Paso Kids Klinic) for any services provided to me by my provider. I authorize my provider to release to the Health Care Financing Administration and its agents any information needed to determine my benefits.

I understand that my signature requests payment be made to pay my claim. My signature also authorizes the release of medical information necessary to pay my claim. My signature also authorizes the release of benefits payable and medical information necessary to pay any secondary insurance payer.

Patient's Primary Insurance & Number:____
Patient's Secondary Insurance & Number:_______________________________________

I have read and I understand El Paso Kids Klinic financial policies and I accept responsibility of associated medical care fees.

____ ________________________

Parent/Guardian Signature **Date**

Patient Financial Responsibility Contract

Please read, initial each blank and sign where indicated – this document describes your financial responsibilities.

This is a legally binding contract between El Paso Kids Klinic and you. The words, *I, me, my, you and your* all refer to the patient.

_____ (initial) I agree to be financially responsible for payment of El Paso Kids Klinic services. Cash or credit cards are acceptable forms of payment for these services.

_____ (initial) Current insurance cards must be presented at every office visit. El Paso Kids Klinic is not responsible for filing your insurance claim, but as a courtesy we will do so. I agree to pay the remaining balance after my insurance has paid on my claim immediately upon receipt of a statement.

_____ (initial) I agree to give El Paso Kids Klinic my complete and accurate insurance information for primary and secondary insurance benefits including referral documents from other providers, if needed. I understand that if I fail to give complete and accurate information about my insurance benefits this may result in a denial of my claim or a delay in payment. I agree to pay El Paso Kids Klinic the balance on my account after my insurance claim has been processed.

_____ (initial) I agree that if my insurance benefit requires me to provide a referral and if the referral is not in place before my appointment, that I will pay in advance an estimate of charges for my office visit or reschedule my appointment.

_____ (initial) I understand that I will be responsible for any missed appointments or any cancelled appointments in which a **24 hour notice** was not given. There will be a fee of $30.00 for any missed office visits and $50.00 for any missed office procedures.

_____ (initial) I understand that all services provided to me by El Paso Kids Klinic are considered medically necessary, if I fail to have a procedure performed or do not comply with my provider's instructions it may be against medical advice and may void my insurance benefits. Should this occur, I agree to pay the balance remaining on my account after my insurance has been processed.

_____ (initial) I understand that my insurance may or may not agree to the usual, customary or reasonable charges for my local area. I understand that my benefits may not cover all services or might deny payment for services that have been approved of in advance. I agree to pay the balance remaining on my account after insurance has been processed.

_____ (initial) If I have a high deductible policy or do not currently have insurance benefits, I agree to pay an estimate of charges for my office visit in advance and understand that other charges may apply.

_____ (initial) El Paso Kids Klinic has a contract with my insurance company. El Paso Kids Klinic will receive payments from my insurance company for ***covered*** services provided by my insurance benefits. I agree to pay co-payments or deductibles at the time of service. If co-payments are not made at the time of service, I understand that my appointment may be rescheduled.

_____ (initial) I agree to pay any balance remaining on my account for any reason upon receipt of a statement and I understand that when requested, I must give El Paso Kids Klinic my current accurate address and other contact information. I understand that if I fail to pay the balance on my account this may result in El Paso Kids Klinic pursuing any collection means possible.

_____ (initial) If my account becomes delinquent, it may be forwarded to an outside collection agency without notice. If this happens, I will be responsible for all costs of collection, including but not limited to interest, rebilling fees, court costs, attorney fees, and collection agency costs. Any delinquencies may be reported to the credit bureau. This does not close your account and you are still responsible for account balance.

ASSIGNMENT OF BENEFITS

I hereby authorize direct payment of medical benefits, including medical benefits to which I am entitled to El Paso Kids Klinic. This is a **DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS**. This authorization will remain in effect until cancelled by me in writing. A copy of this authorization is as valid as the original document.

I authorize the release of any medical information necessary to in order to obtain payment and I understand that I am financially responsible for all charges, late fees, interest, attorney fees and collection charges considered patient responsibility by my insurance company. I understand that if I am not insured I am responsible for the charges of all services provided to me. I authorize El Paso Kids Klinic to deposit checks received on my account when made out in my name.

I have read and I understand El Paso Kids Klinic financial policies and I accept responsibility for the payment of any fees associated with my care.

____ _______________________

Parent/Guardian Signature **Date**

____ _______________________

Witness Signature **Date**