CONSENT FOR TREATMENT/FINANCIAL POLICY

CONSENT: I hereby request and consent to routine and medical care for the patient including all routine examinations, tests, photographs and other procedures. Any tissue removed may be disposed of in the Clinic's customary manner. I acknowledge that no guarantees have been made as to the results of such medical care. I understand a patient has the right to refuse treatment and that my signature below is not consent to any special medical or surgical procedure. In the event that such procedures are recommended, it is the physician's responsibility to explain the nature of the procedure, the reason it is recommended and the risks associated with the procedure. The physician and/or a member of the nursing staff may ask the patient to sign a form confirming consent to the recommended procedure and alternatives to the procedure. Patients are encouraged to insist on any additional information necessary to make an informed decision to consent to or refuse treatment. No patient will be involved in any research or experimental procedure without his or her full knowledge and consent.

ASSIGNMENT OF BENEFITS: I hereby assign to Thompson River Pediatrics, for services provided by Thompson River Pediatrics, all coverage or other benefits available under any government program, insurance policy or plan, and other benefit program, and I direct that all benefits be paid directly to Thompson River Pediatrics.

FINANCIAL AGREEMENT: **Patients WITH Health Insurance:** Due to the many new options in Health Insurance plans it is patients' responsibility to call their insurance company to verify that we are in network with your plan before being seen in our office. Although we can accept most major insurance plans, there are now several new options under those plans that have restricted networks. If your insurance won't cover a visit due to changes in their plan coverage, it is patient responsibility to pay for services. Many health insurance plans require you to pay a copay and we are contractually required to collect this copayment at the time of service. The remaining balance of the charges for your services will be billed to your insurance plan. If you are unable to pay your copayment at the time of service, you may be asked to reschedule your appointment for a future time. If you have an existing balance, you are required to either pay this balance or make financial arrangements with us to pay the balance before your child can be seen (except in a medical emergency). Financial arrangements can be made by calling the Billing Specialist at (970) 619-8139 or stopping by the office between the hours of 8:00 am and 4:00 pm. If your account is more than 120 days overdue, you may be referred to collections. If your account has been referred to collections, you must make payment arrangements before we can schedule an appointment.
Patients who DO NOT have Health Insurance: For those who do not have health insurance, payment for services rendered is required at the time of service. If you are unable to pay at the time of service, please ask to speak to our Billing Specialist.

MEDICAL RECORD RELEASE: I authorize release of all or any part of the patient 's medical record to any person or entity which may be responsible to pay for any portion of the charges incurred . This release to third-party payers may not be revoked as to records of services provided. I authorize release at any time of medical records from Thompson River Pediatrics to any physicians or other health care professionals (and their staff) who may require health information in connection with the patient's current or subsequent health care. This release to health care professionals may be revoked in writing to Thompson River Pediatrics at any time.

REMINDER CALLS: I authorize Thompson River Pediatrics to use an automated system to remind me or my child or the person that I designate of an appointment. The message may ask to bring insurance card, co-payment, and any other information needed for visit. If you do not want to receive an automated appointment reminder, please submit in writing your request to not receive automated appointment reminders.

This form has been fully explained to me, I understand its content, l have had a full opportunity to ask questions concerning this form and any questions I 've asked have been answered to my satisfaction.

Patient Name: _____ **Date of Birth**: ____/____/____

Parent/Guarantor Name: _____

Signature: _____

Relationship to Patient: _____ **Date**: ____/____/____

Witness:_____