www.fresnochildrens.com

INSURANCE INFORMATION

Please list the types of insurance coverage which you have and provide the receptionist with your insurance cards.
Please see the attached financial policy for details regarding office billing practices in the case of your specific coverage.

Primary Insurance Company ____

Policy # ______________________________ Group # ______________________________

Secondary Insurance Company ____

Policy # ______________________________ Group # ______________________________

CONSENT FOR TREATMENT

I hereby give consent for medical or surgical treatment to Fresno Children's Medical Group, Inc. to care for my child. I am the parent or guardian duly authorized to give consent for such treatment.
I understand that I am financially responsible to the above named office for the services rendered. In the event of collection action I shall be responsible for any legal fees incurred.

ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION

I hereby authorize payment directly to Fresno Children's Medical Group, Inc. of any medical/surgical benefits payable to me under the conditions of my policy for service rendered.
I hereby give consent for release to authorized person of financial and medical information concerning care, treatment and charges as may be required to complete all claims for benefits.

PHYSICIAN/LAB REFERRAL

For those patients participating in a managed care plan, it is your responsibility to inform the doctor regarding limitations on referrals for service outside our facility during each visit. Fresno Children's Medical Group will not be held responsible for charges on service incurred for any referral.

FINANCIAL POLICY

1. Each patient is responsible for his/her own bill. The required co-payment must be paid at the time of service. These payments should be cash whenever possible.
2. As a courtesy, the office will submit claims to your insurance carriers when fees are paid at the time of service. It is the insured's responsibility to provide current information regarding any changes with insurance carriers.
3. It is the patient's responsibility to pursue slow payment or non-payment on the part of his/her insurance company directly regarding the claim. We will be happy to assist you with any collection problems. However, keep in mind the bill remains the full responsibility of the patient.
4. There will be a $20.00 service charge for all returned checks. A $15.00 NO SHOW fee will be charged for failure to cancel Well Exams at least 24 hours in advance.
5. Please note - we must insist on monthly payments of 20% of the outstanding balance on all accounts. A bill becomes delinquent after 60 days of no activity.
6. Patients will receive a monthly statement only when there is a balance due. Charges which have been billed to insurance will be marked with an * (insurance pending) until payment and/or an explanation of benefits is received from the insurance company. (Exception: We will abide by billing guidelines and limitations for plans with whom we have made special arrangement). Charges which have not been paid by insurance will be transferred to patient responsibility and you will receive a statement for them. All patient due balances are expected to be paid within 15 days of receipt of the statement.

If at any time you cannot comply with policies indicated above, arrangements must be made in advance. Requests for alternative methods of payment will be reviewed on an individual basis. Every effort will be made to come to an agreeable arrangement.

I have read the above policy and agree to comply with its provisions.

____ ____________________
Parent/Responsible Party Date

____ ____________________
Witness Date

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