Thank you for choosing Comfort Care Pediatrics. We are committed to providing the best care for your children. Delivery of care by this facility will be administered regardless of race, color, creed, social status, national origin, handicap or sex. Please read this statement carefully so you will understand your financial responsibility and our payment policy. It is our intent that the care of our patients is never compromised for financial reasons.

Responsibility for the Bill

All patients and guarantors are financially responsible for timely payments of medical services. As a courtesy, we file insurance claims for payment of bill(s), but the patient/guarantor is ultimately responsible for payment and agrees to pay the account(s).

Acceptance of Insurance

It is the patient's/guarantor's responsibility to understand their own insurance coverage and to schedule their appointments with a doctor who is a provider on their insurance. It is also their responsibility to know where they can go for lab work or other services as referred by the doctor. Comfort Care Pediatrics will file insurance claims on your behalf but is not financially responsible for outside services. **I agree to provide a copy of my insurance card at every visit**, or I may be **charged a $30.00 fee or asked to reschedule the appointment.**

Release of Information

By signing this form, you provide us with the authority to release such information as is necessary to collect from the insurance companies and other third party payers.

Financial Responsibility of Divorced Parents

The parent who seeks medical care for the child is responsible for any unpaid amount. Although divorced parents may have a divorce decree that establishes their financial responsibilities, we are not a party to the decree. We require the parent accompanying the child for treatment to accept primary responsibility for payment of those services. Any responsibility of the other parent, as set forth in the divorce decree, or implied or agreed upon by the parents, will be the responsibility of the parents and we will not be involved.

Payments at Time of Service

Payment for services is expected at the time of the visit. If there is insurance, it is the patient's/ guarantor's responsibility to pay their co-pay or their portion of the bill at the time of service. If for any reason the co-pay is not made at that time, a **$25.00** service charge will be added to the account.

Balance on Account

Balances are due within 30 days of the insurance payment, unless other satisfactory arrangements have been made with the clinic. Any balance over 30 days will be charged an interest rate of 1.5% per month (18% APR). Our office cannot become involved with third party liability matters and we will expect payment from the patient/guarantor.

Bad Debts/Collections/Legal Actions

Comfort Care Pediatrics reserves the right to request payment for outstanding balances. In the event any balance is not paid as agreed, the undersigned agrees to pay collection fees, up to 40% of the balance owing. The undersigned also agrees to pay court cost and attorney fees in addition to the collection fee, as allowed by Utah Code Annotated, Sec. 12-1-11. **A $20 fee will be applied to all returned checks.**

Cancellation Policy

I agree to give a **24 hour cancellation notice** of any prescheduled appointment that I am unable to attend. Appointments that are not cancelled 24 hours in advance will be **charged a fee of $25.00**. This fee is my **PERSONAL** responsibility and not that of my insurance company. The Cancellation Policy also applies to appointments that have been made and then cancelled the same day as well as no show appointments and will be **charged a fee of $25.00**. **It is my responsibility to arrive on time**. If I am more than 15 minutes late for my scheduled appointment, I may be asked to reschedule.

(1) Legal Guardian Signature_____**Date:**_____/_____/_____

Printed Name_____

(2) Legal Guardian Signature_____**Date:**_____/_____/_____

Printed Name_____