THE CHILDREN'S CENTER PATIENT INFORMATION & FINANCIAL AGREEMENT

CHILD'S INFORMATION

Last Name	First Name	Initial	Date of Birth	Gender M F

Home Address Street	City	State	Zip	Home Phone

RESPONSIBLE CAREGIVER OR GUARDIAN INFORMATION

Relationship to child:

Last Name	First Name	Initial	Home Phone	Cell Phone

Address (if different from child's) Street	City	Zip	Employer	Work Phone

Relationship to child:

Last Name	First Name	Initial	Home Phone	Cell Phone

Address (if different from child's) Street	City	Zip	Employer	Work Phone

EMERGENCY CONTACT INFORMATION ** PLEASE COMPLETE **

Name Relationship to Child

Address Street Phone # (H) (W)

City State Zip (Cell)

Emergency contact email address

LIST ALL MEDICAL INSURANCE COVERAGE INCLUDING MEDICAID (if not insured write "none")

Primary Insurance Company	Policy #	Group #

Insured Name	Insured DOB	Relationship to Child

Secondary Insurance Company	Policy #	Group #

Insured Name	Insured DOB	Relationship to Child

Agreement for Extension of Credit

In accordance with the Federal Truth-in-Lending Act, which requires all doctors to give their patients information in connection with extension of credit, please be advised of the following policies that apply to this office:

1. **You are responsible for your own bill.** As a service to you, we will submit insurance claims to any insurance company if you have provided us with the necessary information and a copy of your insurance card
2. Payments/co-pays are due at the time of service, unless payment arrangements have been made with the business office.
3. You are responsible for all deductibles and charges not covered by your insurance company and it will be your responsibility to contact them with questions regarding non-payment of claims.
4. You are responsible to determine if any therapist you see is covered by your insurance plan.
5. Payments are due monthly on any outstanding balance.
6. You will be billed for all legal fees and costs incurred in connection with debt collection including interest at the legal rate on your unpaid balance from the date of default until judgment and from judgment until the balance is PAID IN FULL.

Also, be advised that any and all information given on this form can be used for collection purposes should your account default and collection action become necessary. **The person signing this form certifies that all information given is correct and will be held legally responsible for this account.** Any second or third party private billing is your responsibility.

I, the undersigned, give permission to release information to 3rd party carriers(s) and do assign all insurance benefits for treatment to be paid directly to the above named provider and request that this assignment remain on file with my insurance carrier. I certify that a copy of this assignment shall be as valid as the original.

Signed: _____ **Date:** _____

Insurance Billing/Diagnosis Disclosure

Please understand that we agree to bill your insurance company for services your child receives at The Children's Center. Also understand that in order to bill your insurance company your child will be given a psychiatric diagnosis which will be submitted with billing. Note that not all diagnoses and services are covered by insurance.

As a service to you we will bill any insurance company if you have provided us with the necessary information and a copy of your card. It is your responsibility to contact your insurance company to determine if services being provided are covered. You will also be responsible for payment/co-payments at time of service.

By initialing below you acknowledge you understand your child will be given a diagnosis which will be submitted with billing to your insurance company.

_____ I **agree** to the conditions listed above.
Initial

_____ I **do not want** my insurance company billed.
Initial