

Children's Clinic of Klamath
2580 Daggett Avenue
Klamath Falls, Oregon 97601
Phone: 541-884-1224 Fax 541-884-8030
www.childrensclinicofklamath.com

Financial Policy

Our office, as a courtesy, will bill and try to collect from all other third party payers before billing the client for services. It is the responsibility of the patient to verify that the clinic has their correct insurance information and to inform us of any changes. While every effort to collect from the third party payers is made, responsibility of the charges for service is ultimately that of the client.

Co-Pays & Private Pay Policy:

It is our policy to **collect co-pays at the time of each visit**. If you have no insurance, we request payment in full at the time of each visit. **This office offers a 20% discount** for accounts paid in full at time of service. For your convenience, the Children's Clinic accepts Visa, MasterCard, cash, and personal check. If you are unable to pay for your visit in full on the day of service, an extended payment plan can be arranged with the Office Manager or Physician. These arrangements must be approved **BEFORE** treatment is rendered. If you pay by check and it is returned to us due to insufficient funds by your bank there will be an additional fee of **\$25.00 per check**. The original amount due plus the return check fee must be paid in cash or by credit card within 30 days to avoid additional collection costs.

Insurance:

Your insurance coverage is contracted by your employer for you and your family. The Children's Clinic contracts an outside billing service. We will file your insurance claim as a courtesy to you. Any questions or disputes about the insurance policy will need to be resolved with the insurance carrier, for example what treatment is covered and how much is covered. Not all services are covered as benefits in all contracts. You are ultimately responsible for services rendered to you.

Collection Account Policy:

All accounts are expected to be paid in full. Our extended payment plan is offered with no interest or late fees as long as payments are made according to the contract. Our policy is to send out monthly statements due upon receipt. Should an account become past due (defined as no payment or contact within 30 days of statement) we will send out one reminder statement and if the account becomes delinquent beyond 60 days without notification from you, the account will be assigned to a credit reporting collection service and an additional fee of **\$75 for collection costs will be added**.

Credit or Over payment Policy:

It is our policy that if an overpayment occurs on an account, a full audit will be done after all third party checks have been received. If any refund is applicable it will be processed within 30 days of audit.

I have read this financial policy and understand that regardless of any insurance coverage I may have, I am responsible for payment of my account. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. Please sign below acknowledging acceptance, receipt and understanding of this policy.

Patients Name: _____
(Print Name)

Date of Birth: _____

Responsible Party/ Legal Guarantor Signature

Date: _____