FOUR CORNERS CHILDREN'S CLINIC
Jessica Rensner, CPNP

Financial Policy

*Please note the individual signing this form will be the responsible party for all billing statements and inquiries. This is typically the individual who holds the insurance plan, but parents must agree on who the financial guarantor is for the child(ren). Payment disputes must be solved between the parents, 4CCC will not be involved in disputes over who received the billing statements.

Patient Name:	DOB:
Guarantor Name:	DOB:
SSN:	Preferred Language:
Mailing Address:	
City/ State/Zip Code:	
Best Phone Number:	Leave Message: Y/N
Alternative Number:	Leave Message: Y/N
Email Address:	
Relationship to the Patient(s):	
Do you live with the Patient: Y/N?	

No one will be denied access to services due to inability to pay by 4CCC. The office offers a sliding scale fee for service as well as a same day self-pay rate. Please carefully read the information below and sign as indicated to acknowledge and accept your financial obligations.

- I give authorization to 4CCC to release all information obtained in the course of my child(ren)'s medical treatment necessary to process insurance claims.
- I acknowledge that it is my sole responsibility to confirm with my insurance company that the provider is contracted and in network. All questions about medical, vision/hearing screening, wellness exams, labs, imaging, and immunization coverage must be discussed with my insurance carrier prior to the visit. I agree to pay all copays, co-insurance, deductibles, and non-covered services as determined by my specific insurance plan. I agree to be held responsible for any charges incurred due to the provider being "out of network" with my plan benefits.
- I agree to pay the full copay amount at the time of service
- I authorize payments made directly to 4CCC for services rendered for all benefits available through my insurance plan, and I will be financially responsible for all services deemed not covered rendered by the provider.

- I agree to pay any additional charges that may occur during a well visit. I understand that these other issues are not covered by my insurance's definition of a well visit but are medically necessary.
- I understand that if I fail to pay any balance on my account within 60 days of billing additional actions will be taken. This may include but is not limited to assistance from an external agency unless arrangements are made before the 60-day time period and are approved by 4CCC. If the account is sent to collections, there will be additional fees on top of the balance due.
- I agree to pay for any charges incurred due to referral to a hospital, provider, or lab and recognize that 4CCC has no control of those billed charges. If I take issue with this billing, I will contact the appropriate agency to dispute it.
- I agree to provide 4CCC with a copy of my current insurance card at **all visits**. If my insurance coverage changes at any point, I agree to provide a new card with updated information.
- I am aware that I can elect to be Self Pay but that the amount must be paid in full at time of service to receive the discount. This discount does not apply to any labs that are sent out from the clinic. In addition, I understand that 4CCC offers a Sliding Scale program based on the Federal Poverty Guidelines using family size and household income as defined by the Census Bureau. Participation is based on proof of income and must be approved by 4CCC.
- In case of emergency and I am unable to be contacted, I give my permission to 4CCC to treat my minor child(ren) in the office as required by the events of an emergent situation.
- I have been given the opportunity to review/possess a copy of the HIPAA Notice of Privacy Practice for 4CCC.
- I give permission for telemedicine appointments, when deemed necessary.
- I consent to receive voice, text, and or email notices to contact me about appointment reminders, billing, and health notifications.
- I authorize 4CCC to share immunization information with my child(ren's) school and the Colorado Immunization Information System (CIIS)

Patient Name:	
Patient or Parent/Guardian if Patient is under 18 Full Name:	
Patient or Parent/Guardian if Patient is under 18 Signature:	
Client Signature (18 or Older):	
Date:	