



Kids First Pediatric Clinic, LLC
18676 Willamette Dr. Suite 300, West Linn, OR 97068
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Website: www.kidsfirstclinic.com

Financial Obligation

All payment is due at the time of service.

This office is contracted with many different insurance plans. All patients are expected to provide our office with current insurance information and to understand their benefits. For the convenience of our patients, our providers participate in a variety of managed care plans. Our office also acts as an advocate for our patients with their managed care plans. This may include completing pre-certifications, eligibility verification, or other similar paperwork on behalf of the patient. **Ultimately, the patient is responsible for understanding their benefits and providing our office with current information so that we can handle this paperwork on their behalf in a timely manner.**

Patient Financial Responsibilities

- The patient's guardian is ultimately responsible for the payment for the patient's treatment and care.
 - Patients are responsible for the payment of co-pays, coinsurance, deductibles, and all other procedures or treatment not covered by their insurance plan.
- Payment is due at the time of service, and for your convenience, we accept cash and most major credit cards at our office.**

Primary Care Physician: If you are required by your insurance company to select a primary care physician, this must be done prior to your child's appointment.

Our mission as a practice is to provide for the health and well-being of our patients. Your health insurance is a contract between you and your health insurance company. **You are financially responsible for any non-covered services. By signing our Consent Acknowledgement Form, you acknowledge you agree and fully understand the Financial Obligation Policy**

HIPAA (Health Insurance Portability and Accountability Act)

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly. Obtain payments from third-party payers and conduct normal healthcare operations such as quality assessments and physician certifications. I understand that as part of my healthcare, A Bright Future Pediatrics originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment.

I have received, read, and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*. **By signing our Consent Acknowledgement Form, you acknowledge you agree and fully understand the Health Insurance Portability & Accountability Act.**