KJARTAN D. ARMANN, M.D.
Infant, Child and Adolescent Medicine

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FINANCIAL AGREEMENT AND CONSENT OF TREATMENT

Patient Name:
_____D.O.B._____

IF YOU HAVE MEDICAL INSURANCE: We will file claims to your medical insurance company for the services that are provided by our office. In order for the claims to process correctly, please ensure that the information that is provided to our office on the patient information form is accurate and current. If there is a change in insurance information please let us know immediately. We will submit to secondary insurance as long as we are given the correct information and we are notified that you would like this service done.

Deductibles, Co-Payments and Coinsurance: Co-payments are constant and due at the time the service is rendered. Coinsurance and deductibles vary for each insurance policy. If your co-payment is not paid at the time of service an additional $45 fee will apply.

Authorizations:
A copy of your insurance card is required at the time of the service. The card is descriptive and indicates whether an authorization is needed. **If a copy of the card is not on the file at the time of service and the claim is denied for "no authorization." you will be responsible for the payment.**

Consent for treatment of a minor: I authorize Kjartan D. Armann, M.D. to perform on my child any necessary or routine medical or surgical treatments, including examination, injections, and/or diagnostic procedures, including radiologic studies and/or laboratory analysis. I understand that in unusual circumstances efforts will be made to contact me prior to rendering of treatment, but that medical treatment will not be withheld if I cannot be reached. This authorization will remain in effect unless so designated in writing that such consent for treatment of a minor is rescinded.

Medical insurance coverage is a contract between you and your insurance company. WE ARE NOT a party to this contract. We will not be involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual and customary" charges, etc., other than to supply factual information as necessary. **You are ultimately responsible for the timely payment of your account.**

PAYMENT METHODS AND OTHER INFORMATION:
• We accept cash, check and VISA, MasterCard or Discover.
• Accounts that are past due will be turned over to our collection agency and reported to the Credit Bureau.
• All late cancellations and no-shows will be billed $50 automatically. (We require 24-hour notice in advance to avoid charges.) We are committed to providing you with the best possible care and we are willing to discuss our professional fees at any time. Your clear understanding of our Financial Policy is important to our relationship. Please ask if you have any questions about our fees, Financial Policy, or your financial responsibility.
• Any appointment 15 minutes late on arrival, will be rescheduled.
I acknowledge that I have read and agree to the above Financial Policy.
Signature:
_____Date:_____

Print: _____ Mother Father Other

Witness:_____Date:_____