South Central Public Health District
Prevent. Promote. Protect.

Financial Consent

The goal of our clinic is to provide you with quality health care at a reasonable cost. South Central Public Health District (SCPHD) is not a free clinic. A limited number of fees are available on a sliding scale based upon income and family size. In order to remain affordable, we depend upon you to make prompt payment for services and supplies. In an effort to do this, we have implemented a Financial Policy. This Financial Policy shares responsibility among all our clients.

FINANCIAL POLICY

The following is the Financial Policy, which we require you to read and sign prior to treatment.

- Full payment is due at time of service (including medications).
  Exception: we offer a payment plan with prior approval.
- We accept cash, checks, and credit cards.
- Donations are appreciated for all services.
- No one receiving Vaccine for Children (VFC) vaccines will be denied services due to inability to pay.
- Your account balance does not affect your ability to continue receiving services.
- Your account may be turned over to a collection agency if no payment is received within 120 days after an agency billing.
- We may adjust your account balance to correct any billing errors found after the time of service.

REGARDING INSURANCE:

- All clients must complete a Financial Request Consent before receiving services. Please present your insurance/Medicaid/Medicare card at the reception desk.
- SCPHD will bill your insurance company for you, and the payment may come directly to SCPHD;.
- You may use our services, but we recommend you check with your insurance company regarding coverage.
- SCPHD may not be considered an In-Network provider and therefore cannot guarantee coverage by your insurance company.
- Whether your insurance company pays or not, your account balance is your responsibility.
- Some, and perhaps all, of the services provided may be non-covered services.
- Confidentiality cannot be guaranteed with insurance billing. Your insurance provider may send information to the holder of the insurance policy (who may be your parent, guardian, or spouse).
- Please list those whom you give permission to speak to SCPHD or billing representative regarding your account other than yourself:

Name	Relationship
Name	Relationship

I have read the Financial Consent. I understand and agree to this policy. I also understand that I will be responsible for payment for all services. I authorize release of medical information necessary to process medical claims and authorize payment of benefits to SCPHD.

Signature _____ Date _____