CHILD AND FAMILY EMPOWERMENT SERVICES, LLC

2880 W 4700 S Suite A
Taylorsville, UT 84129-2155
Phone (801) 972-2711
Fax (801) 972-2709

"Where empowerment leads to healthy prevention"

Patient Financial Responsibility Disclosure Statement

Your signature below forms a binding agreement between Child and Family Empowerment Services (CFES-the provider of medical services) and the patient who is receiving medical services, or the responsible party for minor patients (those patients under 18 years old.) Responsible party is the individual who is financially responsible for payment of medical bills.

All charges for services are due and payable at the time of service

We bill many agencies and insurance companies as a service to you. As the responsible party, you are responsible if the agency or insurance company declines to pay for any reason.

The person signing on behalf of the patient as the responsible party must:

- Inform CFES of the current address and phone number for the patient and the responsible party
- Present all current insurance cards or agency forms prior to each office visit
- Verify at each visit that the information is current by signing our data sheet
- Pay any required copay at the time of visit
- Pay any additional amount owing within 30 days of receiving a statement from our office

When CFES receives an explanation of benefits (EOB) from your agency or insurance company, any amounts that you need to pay will be billed to you.

Returned Check Policy

If a payment is made on an account by check and the check is returned as non-sufficient funds (NSF), account closed (AC), or refer to maker (RTM), the patient or the patient's responsible party will be responsible for the original check amount in addition to $25.00 service charge. Once notice is received of the returned check, CFES will send out a letter to notify the responsible party of the returned check. If a response is not made within 15 days from the letter date by the patient or the responsible party, the account may be turned over to our collection agency and a collective few will be added to the outstanding balance in addition to the $25.00 check service charge.

Non-Payment Account

Should collection proceedings or other legal action become necessary to collect an overdue account, the patient or the patient's responsible party understands that CFES has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment for services rendered. The patient or the patient's responsible party understands that they are responsible for all costs of collection including, but not limited to, interest due at 18% APR, all court costs and attorney fees, and a collection fee will be added to the outstanding balance.

CHILD AND FAMILY EMPOWERMENT SERVICES, LLC

2880 W 4700 S Suite A
Taylorsville, UT 84129-2155
Phone (801) 972-2711
Fax (801) 972-2709

"Where empowerment leads to healthy prevention"

Patient Financial Responsibility Disclosure Statement

By signing below you agree to accept full responsibility as a patient who is receiving medical services or as the responsible party for minor patients. Your signature verifies that you have read the above disclosure statement, understand your responsibilities, and agree to these terms.

Patient Name (please print): _____

Patient Signature: _____ Date: _____

Responsible Party Name (please print): _____

Responsible Party Signature: _____ Date: _____