Stanford Children's Health

Agreement to Office & Financial Policies

I have read the policies of Diablo Valley Child Neurology, Inc, and agree to the terms and conditions as described in the "Office Policies" form given to me prior to my first appointment with my child.

Signature: Date:

Name:

HEALTH PLAN ELIGIBILITY CERTIFICATION

Your signature below acknowledges that you agree to accept full financial responsibility for all services provided by Diablo Valley Child Neurology, Inc. in the following circumstances:

- If your child is determined NOT to be eligible for coverage with your health plan and you still would like to proceed with the appointment, then you will be held responsible for payment of the services rendered at the time of the visit.

- With many insurance companies, there are certain diagnoses used in child neurology that may not be covered by your insurance. It may be impossible to predict this prior to the initial assessment. By signing this form, you agree to be held responsible for any diagnoses that are not considered covered under your current insurance premium after services rendered. Once the initial diagnosis is known and is not considered a covered benefit, our office will contact you and let you know the costs for any future appointments. In these cases, we will give a discounted fee for past and future services rendered.

- We will make every effort to ensure that all necessary authorizations are in place prior to your visit. However, if services have NOT been referred or authorized as required by your health plan (an authorization has not been received by our office), then you will be held responsible for payment of service at the time of service.

- The services are NOT payable due to financial instability of your insurance carrier.

I agree to the terms and conditions as described above.

Signature: Date:

Name:

Name of patient: DOB: