**Children’s Last Name(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Children’s First Names: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Office Policy Agreement**

By signing below, I authorize care and treatment by Dr. Matthew Clayton (Village Green Pediatrics) and Dr. Joseph Johnson.
I also agree to the following terms:

***Please Initial***

\_\_\_\_ 1. I acknowledge that Dr. Joseph Johnson will **only** be sending text message billing statements unless I specify with the office.

\_\_\_\_ 2. It is my responsibility to provide my correct/updated insurance information. I understand that this office will bill my insurance as a courtesy and that it is and shall remain my responsibility to pay all amounts owed as set forth herein. (We cannot bill a third-party such as an ex-spouse)

\_\_\_\_ 3. I understand that it is my responsibility to know the details of my specific insurance plan pertaining to copay or deductible. If my insurance requires a copay, I understand that it is due and the time of service and a service charge of $5 will be added if I fail to render payment at that time. I understand that if my insurance plan has a high deductible, a deposit of a minimum of $50 is due at time of service. I will be billed for any remaining balance after claims have been submitted to my insurance.

\_\_\_\_ 4. Payment in full is due within 60 days from the date of service. If payment in full is not made as required, then in addition to all other amounts that may be due, I agree to pay a collection fee of up to 40% of the principal amount as provided by section 12-1-11 of the Utah Code Annotated, and further agree to pay all other costs of collection (whether incurred by Dr. Matthew Clayton (Village Green Pediatrics) or Dr. Joseph Johnson) including by not limited to court costs, reasonable attorney fees, and interest (both pre and post judgement). Any interest due hereunder shall be calculated at a rate of 18% per annum and may, as determined by Dr. Matthew Clayton (Village Green Pediatrics) or Dr. Joseph Johnson: (a) accrue on some or all amounts due and (b) compound as frequently as daily – meaning that accruing interest may be added to the balance owing as frequently as daily such that it shall thereafter constitute part of the amount upon which interest accrues during the next accrual period.

\_\_\_\_ 5. I authorize release of all information to insurance or other third-party carriers and direct them to remit payment directly to the doctor who provided the care.

\_\_\_\_ 6. I hereby consent to being contacted by telephone at any phone number provided to Dr. Matthew Clayton (Village Green Pediatrics) or Dr. Joseph Johnson by me or anyone associated with me or acting on my behalf. I understand that such calls may be initiated by Dr. Matthew Clayton (Village Green Pediatrics) or Dr. Joseph Johnson or any of their affiliates, agents, contractors or assigns, including third-party collection agencies, and that the methods of contact may include using pre-recorded/artificial voice messages and/or the use of an automated dialing device and/or the use of text messages – some or all of which may result in data charges. I also consent to receiving emails at any address provided by me or anyone associated with me or acting on my behalf. I grant each and all of the foregoing permissions, I understand that I am responsible for ensuring my own level of privacy.

\_\_\_\_ 7. I understand there will be a service charge of $25 if I fail to keep an appointment, whether previously scheduled or scheduled same-day. We reserve the right to charge a $25 service fee for appointments that are not cancelled 24 hours in advance. I also understand that confirmation calls/texts/emails are a courtesy and I am responsible for remembering if I have an appointment scheduled for my child.

\_\_\_\_ 8. I understand that if I bring my child over 20 minutes late for an appointment, my child may be seen at the next available appointment that day or rescheduled for another day depending on the workload of the office.

\_\_\_\_ 9. If I bring my child to the office without an appointment and it is determined that my child can not wait until the next available appointment time, or I insist that my child be seen on an emergency basis, I will be charged an emergency visit charge, which is $50 in addition to the regular office visit and other services provided or ordered.

\_\_\_\_ 10. We require at least **24 hours notice** for all prescription refill requests and release of medical records. If medical records are for purposes other than transfer of care to another physician, copies may be assessed a 10 cents per page charge.

**Printed Name of Responsible Party: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of Responsible Party: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**