

**STATEMENT OF EXTENDED FAMILY BILLING AGREEMENT
WITH THE SPRINGFIELD CLINIC**

As the parent of the adult child listed below, I have agreed to maintain the billing for said adult patient on the account belonging to _____ (name of parent), of the adult child listed below:

Adult Child's First Name, MI, Last Name Date of Birth Record #

The agreement is being granted at the mutual request of the adult patient and parent-guarantor. The parent-guarantor of the account will be aware of all services which the adult patient obtains from the Clinic.

1. I understand that I will be held responsible for any Springfield Clinic patient due balance for my adult child while this agreement remains in effect. Initial: _____
2. I understand that it is my responsibility to contact the Privacy Operations Manager to dissolve this agreement, at my discretion. This agreement will remain intact until either myself or my adult child requests revocation. Charges prior to that date remain my responsibility. Initial: _____
3. We understand that the adult child's Account Number will no longer be _____ and will revert back to the parent -guarantors Account Number _____. The adult child's Medical Record Number _____ will remain the same. This is effective immediately, and the Account Number will remain, until the guarantor or adult patient requests separation from the family account. Initial: _____

Guarantor's First Name, MI, Last Name Relationship to Child Date of Birth

**Patient Informed Consent to Waive Privacy Rights
Regarding Billing/Reimbursement Information**

The adult patient must read and initial the following statements to validate the agreement:

1. **I understand that the information disclosed may include matters regarding screening, diagnosis, treatment of sensitive conditions such as mental health, developmental disability, alcohol or drug abuse, infectious diseases including HIV, elective cosmetic procedures, birth control, STD, medical correspondence which may be included on account billing documents.** Initial: _____
2. I understand that I may revoke this agreement at any time, by notifying the Springfield Clinic's Privacy Operations Manager in writing, but the revocation will not affect any actions which the Clinic may have taken prior to the receipt of the written revocation. Initial: _____
3. I understand that it is my responsibility to contact the Privacy Operations Manager to dissolve this agreement, at my discretion. This agreement will remain intact until either myself or the account guarantor requests revocation. Initial: _____

The above conditions are agreed upon and are considered effective as of the date below:

Patient's First Name, MI, Last Name Relationship to Parent Date of birth

Witness First Name, MI, Last Name Date

Clinic Staff: Please route to the Patient Accounting Billing Relations Manager (phone 391-0773) and copy to the HIM Department Privacy Operations Manager.