Central Montana Family Planning
300 1ST Ave N Suite 202
Lewistown, MT 59457
(406) 535-8811 phone & fax
http://www.cmtfp.org

PARENTAL FINANCIAL CONSENT

Your teen has informed us that you are aware of their being seen at our facility for medical services. Your support of our program is very much appreciated. As our charges are based on income and family size we would like you to consider filling this form out so that we can offer you and your teen a sliding fee scale based on the following options available to you the parent/guardian.

If you have health insurance that covers your teen we will bill your insurance company first then provide you a discount based on our sliding fee scale that looks at total family size and total family income. If you only want us to bill insurance then look at the teen's income we can do that as well.

Please check ALL the boxes you feel fit your family's needs and support of our program.

_____By checking this box:
Yes our teen is covered by health insurance

_____By checking this box:
No our teen is not covered by health insurance

_____By checking this box:
Yes I give permission for our health insurance to be billed

_____By checking this box I elect to provide the requested information:
Insurance Company: _____
Group Number:_____
Subscriber ID: _____
Subscriber Name: _____
Subscriber Date of Birth: _____
Subscriber Address: _____

_____By checking this box:
No I do not want insurance billed for my teen's visit

_____ By checking this box:
I prefer my teen be responsible for the cost of their charges based on their own income. (We will only look at your teen's personal income and a possible discount will be offered to them)

_____ By checking this box I elect to provide the requested information:
Total Family Size: _____
Total gross (before taxes) Monthly Income:_____
Total gross (before taxes) Yearly Income:_____

All claims are billed to the insurance company and any allowable charges/balances are then transferred to you/teen at the proper sliding fee scale as you have indicated above. If you elect to help your teen a billing statement will be mailed accordingly.

_____ _____
Parent/Guardian Signature Date

If you have any questions regarding this form or how we charge our teen patients please don't hesitate to call.

Patient Name: _____Date of Birth: _____