Central Montana Family Planning
Montana Cancer Screening Program

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Parent 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:

- Yes, our teen is covered by health insurance. ☐
- No, our teen is not covered by health insurance. ☐
- Yes, I give permission for our health insurance to be billed. ☐
- I elect to provide the requested information. ☐
  - Insurance Company: _____
  - Group Number: _____
  - Subscriber ID: _____
  - Subscriber Name: _____
  - Subscriber Date of Birth: _____
  - Subscriber Address: _____
- No, I do not want insurance billed for my teen's visit. ☐
- 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.) ☐
- 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 or your 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.

Patient Name: _____ Date of Birth: _____

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.