



PAYMENT AGREEMENT

Shodair Children's Hospital staff care about the quality of service we provide to patients and families. Please provide us with your insurance information, be it private or through a government agency, and we would be glad to assist you in determining any financial obligations you might incur during your child's treatment. If your child is not covered by an insurance program, then our staff will provide you with information about other potential options that might exist, such as our program called ShoCare. If you qualify, this program provides financial assistance in the form of discounts and monthly interest-free payments. Our Financial Counselor will send you a program brochure with the first billing statement. Or you may request a brochure at any time by calling 406-444-4507.

Once insurance has been billed and the claim processed, or if you do not have any insurance, any balance due will become your responsibility. We encourage you to contact our Business Office at the number above to review payment options, including applying for the ShoCare program. In the event we do not hear from you to set up payment options, or a bill becomes tardy, your account may be sent to a third-party collection agency. (The collection agency may charge you for attorney fees, out-of-pocket costs of collections and interest on any unpaid balance.)

By signing below as the Responsible Person, you are acknowledging that you have read and agree with your responsibility to pay any balance after applicable insurance and/or government agencies have processed your claim and any discounts have been applied to your account.

Also by signing below as the Responsible Person, this Payment Agreement allows your child to participate in all levels of treatment within Shodair Children's Hospital spectrum of services, including inpatient, residential and outpatient treatment.

RESPONSIBLE PERSON

Printed Name

Signature

Date

SHODAIR CHILDREN'S HOSPITAL

Printed Name

Signature

Date

PATIENT

Printed Name

DOB

Signature (if patient is 16 or older)

Date

**2755 Colonial Drive P.O. Box 5539 Helena, MT 59604
PHONE: 406-444-7500/800-447-6614 FAX: 406-884-2090**