



Lucile Packard  
Children's Hospital  
Stanford

Lucile Salter Packard Children's Hospital

STANFORD UNIVERSITY MEDICAL CENTER • 725 Welch Road, Palo Alto, CA 94304



CONSENT-PERMISSION TO CALL MOBILE PHONE

Medical Record Number

Patient Name

Addressograph Stamp – Patient Name, Medical Record Number

## Our Billing Process

Thank you for choosing Stanford Children's Health as your health care provider. We want to make sure you understand our billing process. We follow the process below to ensure that your claims are paid correctly and timely.

### If you have insurance:

- We will bill your insurance first. Any deductible/co-insurance/co-pay are patient/guarantor's responsibility.
- If you have a secondary insurance, we will bill any deductible/co-insurance/co-pay deemed patient/guarantor's liability after billing your primary insurance to your secondary insurance.
- If your secondary insurance also has deductible/co-insurance/co-pay, these will be billed to the guarantor after the claim has been processed and paid by your secondary insurance.
- You will receive a copy of the Explanation of Benefits (EOB) from your insurance when they process/pay claims submitted to them. Please review and keep for your records. It will explain how the claim was processed and if and why you have any liability.

*\*If you have any questions about your coverage and benefits or why you have a liability on a claim, please contact your insurance for clarification. Please note that some claims takes longer to process than others. In some cases, we have to send an appeal to insurance if claims are not paid correctly.*

### If you do not have insurance:

- You will be billed for the services
- If you have any questions regarding your bill, contact our customer service department at (800)308-3285, Monday – Friday from 8:00AM -5:00PM

It is important that the information we have on file is current and accurate, especially your demographic and insurance information. Please let the front desk representative know if there are any changes to your information so we can update your records accordingly.

By signing below you acknowledge you have been advised of our billing process, and if the primary contact number we have on file for you is a mobile telephone number, you agree that we, Stanford Children's Health, our agents, contractors or collection agency may call you using this mobile number using an automatic telephone dialer and/or leave you a pre-recorded and/or text messages on the mobile number. ***This consent form will remain active unless the guarantor of the account (signee) provides a written request to terminate this consent or the guarantor is changed on the account.***

If you choose not to sign below, please provide us with an alternative phone number to use to communicate billing information to you. PLEASE NOTE: If neither a signature nor an alternate number is provided, you will continue to be liable for any amounts designated as patient liability.

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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