

Pediatric Care of Ogden

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Statement of Financial Obligation and Consent for Circumcision

Patient Name: _____ Date of Birth: _____

Responsibility Party Name: _____ Date of Birth: _____

Circumcision is a surgical procedure in which the foreskin of the penis is removed. By signing this Consent for Circumcision and Financial Obligation form, you are providing permission to perform the surgical procedure, and accepting full financial responsibility for payment of the procedure.

- I. A circumcision may or may not be covered by your private insurance company. It is the responsibility of the parent or guardian to obtain this information. The total cost of the surgical procedure billed to your primary insurance company in a facility or hospital place of service is \$225.00.
- II. Utah State Medicaid does not cover circumcision or local anesthetics used in conjunction with the procedure. No Medicaid plan administered in the state of Utah covers the above described procedure. The cost of the procedure at a facility is \$225.00. Full financial responsibility is the obligation of the parent or guardian of the patient listed above. Circumcision and anesthetics used in conjunction with the procedure are a **NON-COVERED SERVICE**. Pediatric Care of Ogden is not a provider for any Medicaid program outside the state of Utah.
- III. Pediatric Care of Ogden, the provider of services, certifies that this office has an established policy for billing all patients (including Medicaid) for services not covered by a third party. In accordance with State Medicaid provider billing guidelines, the patient has been advised prior to services being rendered the specific cost of \$225.00.
- IV. During the course of the procedure, unforeseen conditions may necessitate additional procedures than those explained. I therefore authorize the below named physician to perform such procedures as necessary. I further consent to the administration of anesthesia as needed.
- V. I understand the proposed procedure involves risk and the possibility of complications. Complications have been known to occur even when the utmost skill and judgment is implemented. I accept the risk in an effort to obtain the desired result of the procedure. I have been given adequate explanation of the procedure, risk and benefit. All of my questions have been answered satisfactorily.

I am the responsible party. I understand my health plan may not pay for services described above. I have been told what the expected cost will be. I have been informed and have signed this agreement before receiving the described services. I have been told why I may be billed. I agree to pay the bill of \$225.00 for the circumcision and anesthetics used in conjunction with the surgical procedure.

Signature of Responsible Party: _____ Date: _____

Signature of Physician: _____ Date: _____

Effective: 10/25/2016