



PATIENT FINANCIAL POLICY

Thank you for choosing the **Oregon Orthopedic & Sports Medicine Clinic, LLP** for your Orthopedic care. We are pleased to serve you.

The following is information about our credit policy. Please read, sign and return it to the receptionist. If you have questions regarding our credit policy, please discuss them with our Business Office.

If you have a medical insurance plan, including Managed Care Plans, Workers' Compensation, Medicare or any other plan, please provide us with the necessary information and a copy of your insurance card. We will gladly bill your insurance companies.

Self Pay Accounts

Self-Pay accounts may be required to pay a deposit at the time of check in. We designate accounts, Self-Pay, under the following circumstances:

- ◆ Patient is covered by an insurance plan our clinic does not participate in.
- ◆ Patient does not have a valid insurance referral on file
- ◆ Patient does not have health insurance coverage.

Payment Due at the time of Service

- ◆ We accept cash, checks, debit & credit cards.
- ◆ All co-pays, deductibles, & non-covered service are due at the time of service unless payment arrangements have been made **PRIOR TO YOUR APPOINTMENT.**
- ◆ All co-pays are due at the time of service. Inability to pay may require your appointment to be rescheduled.
- ◆ If your co-pay is a % and you do not have secondary insurance, a minimum payment of \$20.00 is required at the time of the appointment.
- ◆ Patient balances are due at the time of check in.
- ◆ In the event surgery is needed & you do not have insurance coverage, payment of no less than 50% of the estimated surgeon's fees is required before the surgery is scheduled.
- ◆ All balances are due in full within 30 days of the statement date.
- ◆ If you cannot pay the balance in full within 30 days, our Business Office will work with you to establish a monthly payment plan.
- ◆ We reserve the right to report delinquent accounts to credit bureaus, assess a collection fee, take other collection action, or terminate you as a patient of this practice.

Proof of Insurance

- ◆ Please bring your insurance card & photo identification to every appointment.
- ◆ It is your responsibility to inform the scheduling & registration staff when the injury may be the responsibility of a third party (auto insurance, liability insurance company, worker's compensation) instead of the patient's health insurance.
- ◆ It is your responsibility to notify the practice of changes to your health insurance, address, phone, and employment.

Referrals

If your insurance requires a referral to a specialist, you are required to obtain the referral prior to your appointment. If you do not have a current, valid referral, we may ask you to either reschedule your appointment or pay for the visit at the time of service.



Divorce & Custody

- ◆ In cases of divorce, the individual who receives care is responsible for payment of co-pays, co-insurance, deductibles & non-participating insurance balances at the time of service. We will not bill a divorced spouse for the patient's services.
- ◆ The parent who brings the child to the office for care is responsible for payment at the time of service no matter if the account is self-pay, participating, or non-participating insurance. The clinic does not honor divorce specifics.
- ◆ If a child has coverage with a participating insurance and the proper identification is present at the time of service, the practice will bill the insurance company. Applicable co-pays, co-insurance and/or deductibles are due at the time of service, unless arrangements have been made with the office prior to arrival.

MVA

In cases involving **Motor Vehicle Accidents**, we will bill the carrier only if we can verify fund availability prior to your visit. If unable to do this we will ask that you pay in full for each visit. We will provide you with the necessary billing information for your claim. A MVA claim does not guarantee payment. If your private health insurance requires a referral we ask that you obtain one from your primary care physician to avoid any problems if all or any part of your claim is denied. Should your claim be denied we will bill your private insurance (this is the reason a backup referral is necessary). If you have no private insurance, or our clinic is not contracted with your insurance or should the claim go into litigation, a payment agreement is required between the patient and the Business Office for regular monthly payments.

Worker's Compensation

We will need to verify your claim prior to your appointment date. We need you to provide the necessary information to our clinic well in advance of your visit. If your private health insurance requires a referral we ask that you obtain one from your primary care physician to avoid any problems if all or any part of your claim is denied. Should your claim be denied we will bill your private insurance (this is the reason a backup referral is necessary). If you have no private insurance, or our clinic is not contracted with your insurance, a payment agreement will be required between you and the Business Office for regular monthly payments. A worker's compensation claim does not guarantee payment.

- ◆ I understand that I am responsible for obtaining any referral required by my insurance.
- ◆ I authorize the release of any medical or other information necessary to process claims on my behalf. I agree to be fully responsible for all lawful debts incurred by myself/or my dependent for services received from Oregon Orthopedic & Sports Medicine Clinic, LLP whether covered by insurance or not.
- ◆ I authorize release of information to my primary care physician.
- ◆ I authorize release of information to my employer if this is a work related condition.
- ◆ I authorize photography of my wounds and realize they will become part of my medical records.
- ◆ AUTHORIZATION: I furthermore assign to Oregon Orthopedic & Sports Medicine Clinic, LLP all insurance payments relative to the services performed. I have read and certify billing information as listed above as being accurate. This signature will expire one year from signature date, until revoked in writing, or a change of insurance occurs.
- ◆ I have read the Patient Financial Policy and I agree to abide by all terms.

X _____ / _____ / _____
PATIENT/GUARDIAN SIGNATURE DATE