Welcome to Oregon City Family Practice Clinic, P.C.

Insurance and Financial Obligation

Primary Insurance _____ Policy #_____ Group #_____

Subscriber's Name:_____ SSN # _____ DOB____/____/____

Secondary Insurance_____ Policy #_____ Group #_____

Subscriber's Name:_____ SSN # _____ DOB____/____/____

_____ ***WAYS WE MAY CONTACT YOU***-I understand that OCFP and its partners will contact me by landline phone, cellular phone, fax, email and any way that I have provided in these papers.

_____ ***INFORMATION***-I agree to provide my correct name, current address, phone number, email address, active insurance card, and picture identification at each date of service and to notify OCFP if it changes.

_____ ***PAYMENTS***-Payment is always expected at time of service. This includes deductible, co-pay and any outstanding account balance. OCFP excepts Cash, Visa, American Express and Master card.

_____ ***FINANCIAL RESPONSIBILITY***-I accept financial responsibility for all charges incurred. I understand it is my responsibility to pay any deductible, co-payment, co-insurance or outstanding balance not paid for by my insurance carrier within 90 days.

_____ ***INSURANCE PLANS***-I understand it is my responsibility to know and understand my insurance benefits.

_____ ***INSURANCE CLAIMS***- I understand OCFP will submit my insurance claim for treatment received. I authorize OCFP to release any medical records to a third party payer in connection with a claim for payment. In the event my insurer sends the payment to me instead of OCFP; I agree to endorse the payment over to OCFP with 10 days of receiving said payment.

_____ ***RETURNED CHECKS***-I understand checks returned from the bank for any reason will be charged a $30. administrative fee and my account will be placed on a cash or credit card only basis.

_____ ***MONTHLY STATEMENTS***-I understand that I will received 2 statements. The 3rd statement will note the account as late. Balances not paid will be assessed a monthly late charge of $10.00.

_____ ***LATE ACCOUNTS***-I understand between 90 and 120 days my late account will be turned over to OCFP's collection agency. I understand that it will be reported to outside credit bureaus. I furthermore, understand that I am responsible for any costs including, attorney fees, late fees, and collections fees.

_____ ***NO SHOW, CANCELLATION OF APPOINTMENTS***-I understand that I must cancel 24 hours prior to my appointment or I will be charged a fee of $25.00.

_____ ***MINORS***-I understand that the accompanying parent or guardian is responsible for payment unless court orders are on record. I understand that in order to be treated my minor must be accompanied by a parent or guardian at each visit. There are exceptions please ask OCFP if you need a special arrangement.

_____***PATIENT DISCHARGE***- I understand OCFP reserves the right to discharge a patient for any reason. (Please note that discharges may occur for failure to meet your obligations under this document. In addition, due to quality of care considerations, the practice may discharge you for failure to comply with treatment plan(s) as outlined by your doctor.)

_____***AUTHORIZATION***-I do grant permission to OCFP to administer treatment to myself/child/parent as may be deemed medically necessary.

OTHER IMPORTMANT FACTS:
Our providers will make every effort to receive your calls and respond in an emergency. If you do not receive an immediate response you will call 911, receive paramedic intervention and seek care at the nearest emergency room.
We want you to be an active part of your healthcare, therefore it is your responsibility to know when your medication needs to be refilled. A minimum of 1 week before you run out is recommended. Medications are refilled only at a patient appointment or when requested in advance through your pharmacy.

I have read and I understand all the terms and patient obligations. By my initials and signature below, I agree to follow these policies.

Signature:_____ Date:_____