24076 S.E. Stark, Suite 110
Gresham, Oregon 97030
Phone (503)661-5388
Fax (503)666-9393

FINANCIAL POLICY

I authorize Advantage Orthopedic & Sports Medicine Clinic, LLP, to submit claims to my insurance carrier or its intermediaries for all services rendered. I direct my insurance carrier or its intermediaries to issue payment directly to Advantage Orthopedic & Sports Medicine Clinic, LLP. I also authorize Advantage Orthopedic to release all information necessary to process my claims.

INSURANCE BILLING

It is the patient's responsibility to provide correct billing information. If you have coverage by more than one insurance company, please provide information on all policies and advise us which payer is primary. Your insurance policy is a contract between you and your payer; Advantage Orthopedic is not a party to that contract. It is your responsibility to pay any copay, deductible, coinsurance, or other balance not paid by your insurance. While we understand that you may not always agree with payment decisions made by your insurance, this does not change your obligation to pay any balance remaining after your insurance has processed your claims.

Our insurance contracts obligate us to collect the required copay at the time of service. If you are not prepared to pay your copay, we reserve the right to reschedule your appointment. We do not bill for copays. To provide you with the highest quality service while keeping our billing costs low, we offer paperless billing through our patient portal and through Quick-Pay. We simply maintain your credit, debit or checking account number on file to satisfy all co-pays, deductibles and balances not covered by your insurance.

If you are a cash pay patient (or we are not in network with your preferred carrier), we have two payment options available. On the day of service, depending on the service we will collect a prepayment of either $300.00 for a new patient visit, or $150.00, for an established patient visit. Option 1: Once the visit is completed you may apply the prepayment toward the final balance. Any remaining balance will be your responsibility to pay within 30 days. Option 2: we are happy to apply a 25% discount off the entire visit total, to be paid day of service. We will ask to hold a card up front at the time of check in for liability purposes. Copay in lieu of deposit is accepted only when insurance has been verified. We reserve the right to reschedule your appointment if you are not prepared to pay the deposit fee or office visit copay at the time service is rendered.

WORKERS' COMPENSATION: In order to file a Workers' Compensation claim, you must provide your employer's name, the name of your employer's insurance carrier, the date and time of your injury, the adjuster's name, and claim number. Be sure to notify the registration desk at each appointment if your visit is due to an injury covered by Workers' Compensation. You will be asked to provide your personal insurance information also.

MOTOR VEHICLE: If you have been injured in a motor vehicle-related accident and have no other health insurance, you will be on a cash basis with our clinic. We will provide you with all billing information to submit to the appropriate insurance company for reimbursement; however, we will not bill services for you. If a surgical procedure is required, payment must be made prior to scheduling the surgery.
In the event you also have personal health insurance, we will bill your motor vehicle insurance as primary coverage and bill your health insurance once PIP (personal injury) benefits are exhausted.

LIABILITY CLAIMS: We do not bill Third Party Liability claims as proceeds are paid directly to the injured person. We will provide you with any billing information required but expect payment for all services provided at time of service.

FORM COMPLETION: There is an advance charge of $20.00 per item for completing forms. For example, supplemental insurance, disability, and FMLA paperwork.

RETURNED CHECKS: A $35.00 fee is charged for checks that are returned unpaid by your bank.

I have read, understand, and accept the **Financial Policy** for Advantage Orthopedic & Sports Medicine Clinic, LLP.

_____ _____
Printed Name Date

_____ _____
Patient Signature (or Guardian if patient is a minor) Relationship