

INSURANCE AND FINANCIAL AGREEMENT

Patient Name (Please Print)

Date of Birth

Date

Oregon Neurology Associates is dedicated to providing the best possible care and service to our patients. In order to reduce confusion and misunderstanding, we have prepared the following information regarding our financial policy.

Financial Agreement: Your insurance policy is a contract between you and your insurer, the physician is not involved. We cannot be responsible for collection of your insurance claim or for negotiating a settlement on a disputed claim. Oregon Neurology Associates physicians are participating providers with many health plans, however, plan participation is subject to change. You are responsible for understanding your insurance benefit provided for each visit. If services rendered are not covered by your insurance, you are responsible for payment.

Insurance Claims: Please bring your insurance card with you to each visit. If insurance cards are presented, as a courtesy, Oregon Neurology Associates will bill your primary and secondary (if applicable) insurance plan. If your insurance company does not pay for the services rendered by our physicians, the charges will be your responsibility. In the event we need to appeal a decision by your insurance company, by signing below, you give us permission to do so on your behalf. We will need current and accurate insurance information in order to do this. Please notify us if your insurance plan requires a referral or prior authorization.

Payment Agreement: We have made arrangements with many insurers and health plans to accept assignment of benefit. By signing below, you authorize the assignment of medical benefits to Oregon Neurology Associates. We will bill those plans with which we are contracted and will only require you to pay the authorized co-payment, co-insurance and/or deductible. We will collect this amount from you when you arrive for your visit. If this creates a hardship for you, please do not postpone your appointment, payment arrangements can be made. Failure to abide by your payment agreement will result in your account being forwarded to a collection agency. If you have a balance that has been forwarded to a collection agency you will be required to make a \$100 deposit to schedule your next appointment.

You will receive a statement once we have received a response from your insurance carrier. This statement is due within 30 days of receipt. For your convenience, we accept Visa, MasterCard, American Express and Discover card. If this obligation cannot be met, payment arrangements can be made by calling our Business Office at (541) 868-9430.

Botox injections: Most insurance carriers consider this a surgical procedure, leaving a larger patient balance. We require a \$250 reservation fee to schedule this appointment. Any patient balance remaining on a Botox injection must be paid prior to the next injection. For uninsured patients, a deposit is required prior to scheduling: \$200 for follow ups, \$300 new patients, \$400 for procedures and \$900 per vial for Botox injections. We offer a 25% discount for services paid in full at the time of the visit. If services are not paid in full at the time of the visit, payment arrangements for the remaining balance need to be made with the Business Office.

Additional Charges: The following charges are patient responsibility and not covered by insurance.

- \$10 Late Co-payment Fee charged for co-payments not made at your visit
- \$10 charge for DMV forms or forms requiring only a physician signature
- \$25 per page charge for letters and forms requiring more than a physician signature
- \$35 non-sufficient funds charge for all checks returned by the bank

Overpayments under \$10.00 will not be made without a request.

Consent to Treat: I voluntarily consent to physical therapy, speech therapy, and/or occupational therapy, NCV/EMG, EEG, lumbar puncture, and injections including, but not limited to, Botox, Dysport, Xeomin as ordered by my physician and/or therapist.

Canceled, Missed or No-showed Appointments: If you are unable to keep your scheduled appointment, we ask that you notify the office 24 hours in advance so that we may allocate the time to another patient that needs our care. Our 24-hour phone number is (541) 868-9430. Except in the event of an emergency, failure to give 24 hours notice will result in a fee ranging from \$25-\$100. The patient is also responsible for any fees that ONA incurs due to the canceled, missed or no-showed appointment (Ex: interpretation fees). This fee is not covered by insurance and must be paid prior to scheduling your next appointment. No-showed appointments will be rescheduled with a Physician Assistant in our office.

Release of Information: I hereby authorize Oregon Neurology Associates to furnish the insurance company, employer, or other payer or their representatives, any and all information required to process my claim. Special permission is necessary to release information where the patient is being treated for drug/alcohol abuse, mental health, or HIV related conditions.

I have read and understand the financial policy and agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

Signature of Patient or Responsible Party

Name of Responsible Party (Please Print)