Mtn. View Family Practice, P.C.

Payment Policy and Patient Responsibility

Thank you for trusting us as your primary care provider. We are committed to providing you quality and affordable health care. Please read the following policies and sign below in the space provided. A copy will be provided to you upon your request.

1) **INSURANCE**-Knowing your insurance billing information and benefits is your responsibility. Please contact your insurance company with any questions you may have regarding eligibility and covered services.
2) **CO-PAYMENTS-**All co-payments are patient responsibility and must be paid at the time of service. This arrangement is part of the contract between you and your insurance company. If your co-pay is not paid at the time of service, an additional $10.00 charge will be added to your account.
3) **DEDUCTIBLES & CO-INSURANCE-**All deductibles and co-insurance amounts are patient responsibility and will be billed to you after insurance has processed the claim. This arrangement is part of the contract between you and your insurance company.
4) **NON-COVERED SERVICES-**Please be aware that some or all of the services provided to you during your visits may not be covered by your insurance company. Any non-covered charges are patient responsibility. Please call your insurance carrier for more information on any non-covered services.
5) **PROOF OF INSURANCE-**All patients must complete the patient registration form before receiving any services through our facility. We also require a copy of a valid photo ID, such as state license, and a copy of your current insurance card. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of the claim in full.
6) **CLAIMS SUBMISSION-**Your insurance benefit is a contract between you and your insurance company. As a courtesy to you, we will submit claims to both primary and secondary insurance. Some insurance companies require patients to submit information directly, if so, this is your responsibility. Please be aware that the balance of the claim is your responsibility if your insurance company does not pay.
7) **COVERAGE CHANGES-**It is important to notify us as soon as possible of any changes pertaining to your insurance coverage. Failing to do so may result in unpaid claims and you may be responsible for the balance of the claim in full.
8) **UNINSURED/SELF-PAY PATIENTS-**If you are seeking medical services at our facility and do not have insurance or are underinsured, a minimum deposit is required for each visit. You will be notified of any additional charges for further services or testing prior to them being performed.
9) **MOTOR VEHICLE ACCIDENT (MVA)-** If you are receiving treatment as a result of an MVA, it is your responsibility to provide us the claim information which will then be verified with the insurance company prior to your scheduling. If we are unable to verify the claim information and you do not have regular medical insurance, you will be responsible for paying as an uninsured/self-pay patient until verification is made. If your claim is denied, we will bill your regular medical insurance, if any, and you will be required to pay all amounts not covered by your insurance.
10) **WORKERS COMPENSATION (WC)-**If you are receiving treatment for a work related injury, it is your responsibility to provide us the claim information, which will be verified prior to your appointment with the insurance company, and accurately complete an 827 form which we will provide. If we are unable to verify the claim information or do not receive the completed 827 form and you do not have regular medical insurance, you will be responsible for paying as an uninsured/self-pay patient until verification is made. If your claim is denied, we will bill your regular medical insurance carrier, if any, pursuant to ORS 656.313 and you will be required to pay all amounts not covered by your medical insurance.
11) **ON CALL/AFTER HOURS**-After hours calls are FOR EMERGENCIES ONLY. Non-emergency calls may result in a $45.00 charge billed directly to the patient based on review by the medical provider on-call.

12) **PERSCRIPTION REFILLS**-If you are in need of a prescription refill, you must call your pharmacy at least 48 hours prior to running out of your medication. If no refills remain, your pharmacy will contact us directly to request additional refills. Please note, our on-call providers may not be able to refill medications during evening and weekend hours.
13) **PHONE CONSULTS**-Phone consults are not covered by medical insurance. If you would like a phone consult by one of our medical providers, the charge is $45.00 and will be billed directly to you.
14) **STATEMENTS**-Patient statements are mailed monthly and payment is due no later than the 25th of the same month. If payment is not received by the 25th of the month or arrangements for payment have not been made, a $5.00 per month finance charge will be assessed on any unpaid balance remaining. If balances remain unpaid, we reserve the right to refer your account to a collection agency and charge a processing fee of $10.00. Partial payments will be accepted after satisfactory arrangements have been made with our billing department. A statement will not be mailed for balances under $5.00 and will be collected at your next visit.
15) **RETURNED CHECKS-**If your check for payment is returned NSF, your account will be charged a $25.00 fee.
16) **MISSED, CANCELLED, & RESCHEDULED APPOINTMENTS**-We require a 24-hour notice on all appointment cancellations or reschedules. Our policy is to charge a $45.00 fee billed directly to the patient or responsible guardian for missed appointments and failure to give more than 24 hours advance notice. The $45.00 fee must be paid prior to receiving additional services through our facility. If you fail to keep an appointment due to unforeseen circumstances, please discuss this with our clinic manager or billing department. After two missed appointments or cancellations and reschedules without 24 hour advance notice, your account will be reviewed for possible discharged from our facility.
17) **HARASSMENT**-This is a private practice in Family Medicine where we strive to create a pleasant environment for all patients and staff. We understand that there are times when patients may be frustrated and we will make every attempt to assist you. However, this practice will not tolerate physical abuse, verbal abuse, or harassment of any kind, under any circumstance. Abuse or harassment in any form is grounds for immediate discharge of the entire family from the practice.
18) **PAIN MANAGEMENT**-Our providers do not treat or manage chronic pain. The American Pain Society defines "chronic pain" as pain that lasts more than 6 months, is ongoing, is due to non-life-threatening causes, has not responded to current available treatment methods, and may continue for the remainder of a person's life. If you are suffering from chronic pain, your provider will discuss with you other options for seeking treatment.
19) REFFERAL TO OUTSIDE FACILITY-You have a choice. If this clinic refers you to another facility for a diagnostic test or health care treatment, and/or service, you may receive that diagnostic test, health care treatment, and/or service at a facility other than the one recommended by this clinic. If you choose to have such test, treatment, and/or service done at a facility different from the one recommended, you are responsible for determining the extent of coverage or the limitation on coverage for the test, treatment, and/or service at the facility of your choosing. This clinic will not deny, limit, or withdraw a referral solely because you choose to have the test, treatment, and/or service at a facility other than the one recommended by this clinic.

"I acknowledge that I have read, understand, and will follow all policies and responsibilities stated above. I acknowledge that I am financially responsible for all charges associated with services rendered. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, I, the undersigned, agrees to pay for all legal costs and expenses, including reasonable attorney fees. I also, hereby, authorize Mtn. View Family Practice, PC to release information necessary to secure payment."

_____
Patient Name (Print)

_____ _____
Patient or Legally Authorized Representative Signature Date

_____ _____
Legally Authorized Representative (Print) Relationship to Patient