

Lake Oswego Family Physicians, PC

Name: _____ Date of Birth: ____/____/____

There may be times when the LOFP staff may need to contact you regarding appointments, test results, or other communications. In order to contact you, we need authorization of the following methods of communication: **(By checking the following boxes, you authorize LOFP staff to contact you. Please do not check boxes that you do not want to authorize.)**

- 1) I authorize LOFP staff to contact me and leave a message at my home by telephone.
- 2) I authorize LOFP staff to contact me and leave a message on my cell phone.
- 3) I authorize LOFP to contact me and leave a message at work.
- 4) I authorize LOFP staff to leave a message regarding all aspects of medical care with the following persons:

Please read & initial the following:

* Patients must provide adequate personal information and a current health insurance card if insurance is to be billed. If you do not have your insurance card, you will be asked to pay in full at the time of service or we will reschedule your appointment. In the event there are any changes to your personal or insurance information, LOFP must be notified.

Initial _____

* We will bill insurance as a courtesy, but please remember an insurance policy is a contract between you and your insurance carrier. It is the patient's responsibility to obtain a referral if their insurance requires and to contact their insurance carrier with any questions or disputes regarding the policy, covered treatments, amount paid, etc. Ultimately, the patient is responsible for timely payment on their account. **All co-pays, deductibles, and non covered services are due at the time of service.**

Initial _____

* All private pay portions of a patient's account are due and payable at the time of your visit unless satisfactory arrangements have been made with the Accounts supervisor. Any account with a private pay balance outstanding over 60 days may incur a \$10/month rebilling fee. Any non sufficient fund checks will be assessed a \$35.00 fee.

Initial _____

* Delinquent accounts may be assigned to a credit reporting agency and will be charged a \$30 collection fee will be added to the past due amount. If it becomes necessary to effect collections of any amount owed on this or any subsequent visits, the undersigned agrees to pay all costs and expenses including reasonable attorney fees.

Initial _____

* Motor Vehicle Accident Claims: Our office does not bill any third party carriers. If a patient is involved in a motor vehicle accident, the patient will be asked to pay for all services in full. It will be the patient's responsibility to seek reimbursement from the Automobile Insurance Company.

Initial _____

* Worker's Compensation Claim: LOFP accepts new Worker's Compensation claims and only if the patient is covered under a private/group health insurance plan as well.

Initial _____

* I agree that I have had the opportunity to review and understand the HIPAA Notice of Privacy Practices.

Initial _____

I authorize LOFP to furnish information to insurance carriers concerning illness or medical treatment of my dependants and myself, and I hereby assign to the provider all insurance payments otherwise due me for medical services rendered to myself or my dependants, except those services for which I have already paid for prior to the filing of the insurance claim on my behalf. By my signature below, I acknowledge that I have read, understand, and agree to the above financial policy and agree to accept responsibility for payment in full on my account. A copy of this signature is as valid as the original.

Signature of Patient or Responsible Party

Date