

EAST PORTLAND ORTHOPEDIC AND FRACTURE CLINIC
135 NE 102nd AVENUE
PORTLAND, OREGON 97220
(503) 255-5388

FINANCIAL POLICY

We are pleased that you have chosen the providers at East Portland Orthopedic and Fracture Clinic.

For your convenience, we accept cash, checks, VISA, MasterCard, Discover, American Express, and Bank Debit Cards.

Insured patients are responsible for all charges resulting from treatment provided by East Portland Orthopedic and Fracture Clinic. **Co-payments will be collected at appointment check in.** It is important to understand the insurance contract is between you, the patient, and your insurance carrier. We are happy to submit claims to insurance carriers as a courtesy to the patient. **However, we ask that the patient pay the required co-payments, deductibles, or uninsured amounts at the time services are rendered.** We do not bill third party insurance carriers.

Uninsured patients will be expected to pay \$250.00 at the time of check-in for their first appointment. If the charge exceeds \$250.00, or if surgery is indicated, a representative from the business office will speak with the patient and/or the patient's guarantor. Payment is required prior to treatment and/or surgery. Pre-payment cash discount is 20%. Pre-payment check or charge card discount is 15%.

Please note that we charge for the following:

- \$10.00 Disability Form**
- \$25.00 Returned Check Charge**
- \$30.00 Copying Records First 10 Pages, 11-50 pages \$.50 each, 50 pages or more \$.25 each**
- \$40.00 Less Than 24 Hour Cancellation or Missed Appointment**
- \$62.00 MVA Lien Filing Fee/Lien Release Fee**
- \$100.00 No show for injections**
- \$250.00 Surgery Re-scheduling and/or Cancellation Fee**

All Patients are required to complete the clinic's patient information sheet in its entirety, including information showing Social Security number.

I authorize payment of insurance benefits directly to the Timothy J. Treible, M.D. or East Portland Orthopedic and Fracture Clinic. If the amount paid by the insurance company is insufficient to cover charges, I understand I will be responsible for the remaining balance. All non-covered or partially covered charges are due in 30 days from the date of service, unless other arrangements have been made with the Business Office. Patients without insurance are required to pay in full at the time of service. Please note that guarantor accounts 31 days old are considered past due. PAST DUE accounts will be charged a FINANCE CHARGE of 1½% per month (18% per annum). Minimum finance charge is 50 cents. If an account is assigned for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and court costs

PHYSICIAN RESPONSIBILITY DISCLAIMER: As the subscriber to the insurance, you are responsible for making sure that we know at the time of scheduling office visits, tests, surgeries, physical therapy, etc., if your insurance company requires pre-authorization and/or a referral, and what facilities you may use. We will do our best to insure that these are authorized and scheduled at the correct facility. You may be responsible if an error is made.

I understand that in order to cover this visit, **my insurance company may require a referral from my Primary Care Physician. I also understand that if an authorization from my Primary Care Physician is not received, I will be responsible for any and all charges incurred, including x-rays, at the time of service. I acknowledge that regardless of insurance coverage, I am ultimately responsible for payment of the bill.**

Patient Signature/Responsible Party: _____ Date: _____