Billing for Services Notification

Patient Name: _____ **Medical Record #:** _____

DOB: _____ **Today's Date:** _____

REQUEST FOR TREATMENT: I hereby request medical treatment from Hope Orthopedics of Oregon. I hereby consent to the performance of all treatments and tests, which may be considered advisable or necessary by the attending physician.

REGARDING INSURANCE BILLING: We will gladly bill your insurance carriers. Please make sure we have the appropriate information. In some cases, delay or failure on your part to complete insurance requirements such as accident waiver forms, etc. means that the total balance will become your responsibility. In the event you have sustained your injury due to a motor vehicle accident, we may file a lien for the amount due. Once the account has been paid we will satisfy the lien.

By signing this form, you assign insurance proceeds, for which you are entitled for the services performed, to Hope Orthopedics of Oregon. This assignment does not relieve you from responsibility for charges not paid by your insurance company. You also acknowledge that your health insurance may not pay for surgical services and you agree to pay for these services, personally, if not covered.

REGARDING ESTIMATED PATIENT BALANCES: You may be asked to make co-payments required by your insurance in advance. For your convenience we accept payments in person, through our website at www.hopeorthopedics.com, or through our patient portal. Returned checks and bank disputed credit card charges will be assessed a $35 fee.

REGARDING BILLING WHEN NO INSURANCE COVERAGE IS AVAILABLE: If insurance coverage is not available and you are unable to pay in full on the date of services, you may be asked to complete a credit application and authorize us to request a credit report from a national credit reporting company. Financial arrangements will be made with our Business Office.

REGARDING BILLING IF THIRD PARTY ACCIDENT: I hereby authorize and direct my attorney and/or my insurance company to pay directly to Hope Orthopedics of Oregon all such reasonable and necessary sums as may be due and owing to this office for services rendered by reason of accident or illness and to withhold such sums from any disability benefits, including but not limited to health and accident benefits, PIP benefits, workers compensation benefits or any other insurance benefits obligated to reimburse the undersigned or from any settlement, judgment or verdict on my behalf as may be necessary to adequately provide for any financial obligation owed this office and assignee.

The parties agree that, in the event my insurance company is obligated to make such payments, this agreement is to act as an assignment of the undersigned's rights and benefits to the extent of the cost of the services provided by this office. Therefore, I hereby assign and transfer to this office and assignee any and all causes of action that I might have or that might exist in my favor against such company and authorize this office and assignee to prosecute said cause of action either in my name or the assignee's name and further I authorize this office and assignee to compromise, settle or otherwise resolve said claim or cause of action as they see fit. A photocopy of this assignment shall be considered as effective and valid as the original.

The undersigned further understands and agrees that this assignment and authorization does not constitute any consideration for the office to await payment and that they may demand payment in full immediately upon tendering service at their option. It is understood that as necessary the necessary health care provider may submit, prepare or complete medical reports, consultations, depositions and court appearances on my behalf which are not considered part of my account unless such is approved in advance.

I authorize the health care provider to release any information pertinent to my case to any insurance company, adjuster, attorney or legal service bureau to facilitate collection under this assignment or authorization.

I understand and agree to the foregoing rights and responsibilities.

Signature of Patient or Responsible Party: _____ Date: _____

Hope Orthopedics of Oregon
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