Patient Financial Policy

Financial Policy

Hope Orthopedics of Oregon (Hope) accepts many insurance companies and plans. While our providers are commonly "participating providers" of many major insurance companies, your individual coverage is not verified by our staff prior to your initial appointment. You should contact your insurance company directly with coverage questions. Please note that co-pays and deductibles usually apply to services and treatments provided at Hope.

Non-Discrimination

Necessary medical services will be provided regardless of the patient's ability to pay in an emergency situation (life or death).

Patients with Insurance

Verification of Information: All information given to Hope regarding the ability to pay, third party insurance, alternate resource, etc., will be subject to verification.

Assignment of Benefits: Hope will bill insurance and alternate resources as a courtesy to you, if you provide the required insurance information and sign an assignment of benefits statement. Our office accepts assignment for Medicare.

Partial Insurance Coverage: Patients with insurance policies that cover only a portion of treatment must pay the difference between actual charges and the anticipated insurance payment. Copays are due at the time of service. All remaining co-insurance amounts are billed on a 28 day billing cycle.

Patients without Insurance or Insurance with High Deductibles

Payment for all charges which are not covered by insurance, are due and payable at the time of service, unless other arrangements are previously made.
A pre-treatment deposit of $100.00 is required for an initial visit and a $100.00 deposit will be required for each subsequent visit. The remaining balance after receipt of the deposit will be billed on a 28 day billing cycle.

Please note if you have a procedure that requires laboratory testing, you will receive an additional bill from the laboratory.

Payment Terms

Payment Methods: Hope accepts payments in person or online at www.hopeorthopedics.com. Electronic payments are also accepted via our patient portal are available once the patient has enrolled and received an initial statement.

Payment Arrangement: If the responsible party is unable to make full payment of the balance owed when due, periodic, or partial payment may be approved in accordance with the Hope credit and collection procedure. The individual's payment history will be taken into consideration when approving payment arrangements.

Unpaid & Bad Debt Accounts: Prior to providing services, payment for all outstanding accounts will be requested. In some circumstances, payment arrangements may be made. If the patient is self-pay with no insurance, a payment arrangement may or may not be made for the past due balance and all other visits will be due at the time of service. Accounts that cannot be collected by the Hope billing department, after normal in-house collection, may be referred to a collection agency in accordance with our collection procedure. Patients with accounts that are in collections will be suspended from receiving care with Hope. Accounts which have been written off to bad debt may also be denied future treatment if not deemed an emergency (life or death).

Returned Payments: Returned checks and bank disputed credit card charges will be assessed a $35 fee.

Refunds: Overpayment will be refunded to the appropriate party. Patient refunds will not be processed until all active or past due accounts are paid in full.

Surgery Financials

Surgical candidates may receive statements from as many as six separate entities including but not limited to, Hope Orthopedics of Oregon, Willamette Surgery Center, Salem Hospital, the anesthesiologist and the laboratory that processes your clinical laboratory report.

Agreement: *The information I have provided to Hope Orthopedics of Oregon (Hope) is correct and true to the best of my knowledge. By signing below, I assign benefits to Hope and authorize them to furnish information regarding my medical condition to my insurance carrier. I understand that I am responsible for any amount not paid by my insurance per the provisions of my policy. I have read and understand this financial policy. My signature below indicates that I accept this policy and agree to abide by the terms of it for my treatment at Hope.*

Patient Signature _____ Print Name _____

Date of Birth _____ Date _____