Billing for Services Notification

Patient's Name:_____ Today's Date:_____

DOB:_____

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. Return checks and bank disputed credit card charges will be assessed a $35 fee.

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.

Patient Financial Policy

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

Uninsured Patients / Non-covered Services: 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 pretreatment 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 cash, check, debit/credit cards, and CareCredit. Electronic payments via our patient portal are available once the patient has enrolled and received an initial statement. Payment may also be made via our website at www.hopeorthopedics.com.

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).

Non-sufficient Funds: Returned checks and bank disputed credit card charges will be assessed a $35.00 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.

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).

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.*

Signature of Patient or Responsible Party: _____ **Date:** _____