Patient Financial Agreement

Please read the following information closely. If you have any questions, please ask.
We want to ensure that you completely understand our financial policies.

1. Oregon Medical Group (OMG) participates with Medicare, Medicaid and many commercial insurances. While OMG may have an agreement with your insurance, it is your responsibility to know if your plan is in network. By contract, covered charges will be paid directly to OMG. Any applicable co-insurance payments and/or deductibles are due at the time of service. Failure to make the appropriate co-payment at the time of your office visit may result in the re-scheduling of your medical appointment.
2. When an account balance becomes your responsibility, the balance is due upon receipt of the first account statement from OMG. If any part of the account balance becomes delinquent, then the account balance may be forwarded to an outside agency for collection. A $35 returned check fee may be assessed for non-sufficient funds.
3. If you make an appointment for a wellness visit/physical only and your doctor treats you for an illness or counsels you regarding a medical condition during the visit, there could be a separate co-payment that is your responsibility.
4. A deposit of $100 is required for all patients who do not have insurance; have insurance that is not contracted with OMG; reside outside of Lane County; or have an Out-of-Area Primary Care Physician.
5. During your appointment, your provider may order additional medical services, such as laboratory tests, which will need to be sent out of the clinic to be processed. In this case, you may receive a separate bill from an external company, which will be your responsibility.

I understand that it is my responsibility to know what the terms of my insurance are, and in compliance with those terms, agree to the following:

I will pay all applicable co-pays and outstanding balances as they become due.

I assign medical benefits paid by my insurance carrier(s) to OMG, for application to my bill. I acknowledge that I will be billed for charges not covered under my insurance policy.

I hereby authorize OMG to furnish the insurance company, payors or their representatives, any and all information required to process my claims, which may include treatment/testing for HIV-related conditions.

I have read and understand OMG's financial agreement and I agree to be bound by its terms. I understand that my refusal to sign this form will be interpreted as my decision to cease receiving medical care with OMG.

Patient Signature (or responsible party, if patient is a minor) ______________________ Date ______________

Print Patient Name ______________________

Print Responsible Party Name (if different from patient) ______________________