PATIENT FINANCIAL AGREEMENT

Oregon Medical Group is dedicated to providing the best possible care for you, and we want you to completely understand our financial policies.

1) Oregon Medical Group participates with Medicare, Medicaid and Commercial Insurances. While Oregon Medical Group 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 us. 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 the responsibility of the patient, the balance is due from the patient on receipt of the first account statement from OMG. If any part of the patient 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) <u>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.</u>

4) A deposit of $100 is required for all patients that do not have insurance, have insurance that is not contracted with Oregon Medical Group or is 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 the patient's 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 Oregon Medical Group 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.

Signature of patient (or responsible party, if patient is minor) Date

Please print the name of the patient and responsible party (if different from patient)