PATIENT FINANCIAL RESPONSIBILITY POLICY

Patient Financial Responsibilities
The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for treatment and care.
We will bill your insurance for you. However, you as the patient, is required to provide the most correct and updated information regarding insurance. Our staff will request your insurance card at each and every appointment.
Patients are responsible for payment of copays, coinsurance, deductibles and all other procedures or treatment not covered by your insurance plan at the time of service. Our collection policy also includes that unpaid past due balances may be forwarded to a collection agency or pursuing legal action.

- Copayments are due at the time of service per your insurance policy.
- Coinsurance, deductibles and non-covered items are due at the time of service.
- Patients may incur, and are responsible for payment of additional charges, if applicable.

These charges may include:

- Charge for returned checks $30.00
- Charge for missed appointments without 24 hours prior notice $100.00
- We asses a 3% surcharge for credit card transactions. We impose a surcharge on credit cards that is not greater than the cost.

Motor Vehicle Accidents
Motor Vehicle accident information must be provided prior to your scheduled appointment. If you want us to bill your automobile insurance, please provide us with the insurance company name, address and phone number, claim number, adjusters name and phone number. We will bill your automobile insurance as a courtesy but you are responsible for all balances.

Workers Compensation
Workers Compensation information must be provided prior to your scheduled appointment. Your services will need to be authorized by your Adjuster. If your claim is in litigation, we will need to have your attorneys name, address and phone number prior to treatment. If any of this information cannot be verified, your appointment may be rescheduled.

Disability Forms
A fee of $40.00 will be charged to complete disability forms. Payment is required prior to form completion. This fee is waived if you have surgery scheduled and up to 3 months after surgery.

Patient Authorization
By my signature below, I hereby authorize Oregon Spine Care and the physicians, staff and hospitals associated with Oregon Spine Care to release medical and other information acquired in the course of my examination and/or treatment (with the exceptions stipulated below) to the necessary insurance companies, third party payers, and/or other physicians or healthcare entities required to participate in my care.
I understand that I must check one or more of the following types of health information to indicate that I authorize that information type to be released to the necessary insurance companies, third party payers, and/or other physicians and/or healthcare entities required to participate in my care.

By initialing one or more of the below, the health information I authorize to be released may include any of the following:

_____ Record of alcohol and/or drug abuse.
_____ Record of HIV (AIDS) result, diagnosis, and/or treatment.
_____ Record of psychiatric and/or psychological condition

By my signature below, I hereby authorize assignment of financial benefits directly to Oregon Spine Care and any associated healthcare entities for services rendered as allowable under standard third party contracts. I understand that I am financially responsible for charges not covered by this assignment.
By my signature below, I authorize Oregon Spine Care to communicate by mail, phone, and/or voice mail message, according to the information I have provided below:

Please read and then choose YES or NO:
If you are unavailable, may we leave medical information, such as appointment reminders, lab results and financial information on your voicemail or with someone at your residence?

__________YES __________NO

If yes, please list name and relationship of person(s) we are authorized to discuss your medical care and/or account:

Name	Relationship	Name	Relationship
____________________	____________________	____________________	____________________
____________________	____________________	____________________	____________________

Oregon Spine Care LLC is committed to protecting the privacy of our members' personal health information. Part of that commitment is complying with the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which requires us to take additional measures to protect personal information and to inform our members about those measures.

I have read, understand, and agree to the provisions of this Patient Financial Responsibility Form:

____

Signature of Patient and/or Guardian Date
Relationship to Patient: ____________________________________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge and agree that I have received a copy of our Notice of Privacy Practices for Oregon Spine Care, LLC or Robert L. Tatsumi MD PC.

Patient Name: ____

Patient Signature:____

Date: ____

Name of Patient Legal Guardian or Representative: ___________________________

Relationship to Patient: ____

Signature of Patient Legal Guardian Representative: __________________________

Date: ____

OFFICE STAFF USE: Oregon Spine Care, LLC or Robert L. Tatsumi MD PC have made good faith efforts to obtain the above referenced individual's written acknowledgement of receipt of the Notice of Privacy Practices. Staff initials ________ Date: _________________