



CASCADE ORTHOPEDICS AND SPORTS MEDICINE CENTER, P.C.  
 1715 EAST 12<sup>TH</sup> STREET  
 THE DALLES, OR 97058  
 541-296-2294

**FINANCIAL POLICY**

In the interest of good healthcare practice, it is desirable to establish a Financial Policy to avoid misunderstandings. Our primary responsibility is to help our patients experience good health and we wish to spend our time and energy toward that end.

We are committed to providing you with the best possible care. Our fees reflect our professional commitment to excellence. If you have insurance, we are happy to help you receive your maximum allowable benefits. In order to achieve these goals we need your assistance and your understanding of our payment policy. For the convenience of our patients we offer the following methods of payment of fees.

- Payment in full by cash, bank card or alternate financing of each appointment as service is rendered. Alternate financing (payment plans) must be arranged before treatment is rendered.
- For insurance patients, we will accept payment directly from the insurance company only for that percentage the company will cover and do require that the deductible and non-covered fees be paid at each visit.
- Bank charge cards - Visa, MasterCard and Debit card are accepted.
- If your account is overpaid, a refund will automatically be issued. If the amount of the credit is less than \$20 you agree that the clinic will assess a service fee equal to the credit balance to avoid the administrative costs associated with processing a refund.
- Lost or damaged refund checks issued by COSMC will be replaced after 90 days of being notified by the individual who was issued the refund check, and confirmation from our bank that the check has not been cashed in that 90 days. A charge of \$35 will be applied to the refund if the replacement refund check is requested to be received before the 90 days.

**Our office staff understands insurance, and we will be glad to assist you in obtaining the maximum benefits specified in your contract. It is important that you realize however:**

- Your insurance benefit is a contract between you, your employer (if applicable), and the insurance company. We are not a party to that contract. This office files your insurance claim as a courtesy to you. We will bill your PRIMARY and SECONDARY medical insurance plans as long as they are provided at the time treatment begins.
- If your insurance plan requires referral from your Primary Care Physician, we ask that you phone your Primary Care Physician prior to your appointment for the necessary authorization. **Lack of referral could result in patient responsibility for services requested on that day.**
- Our fees generally, but not necessarily, fall within the usual and customary fee structure determined by your insurance company.
- Not all services are a covered benefit in all contracts.
- You (not the insurance company) are responsible to us for all fees for services rendered to you.
- Upon request, a pre-determined estimate of benefits can be given to you.
- We will gladly discuss your proposed treatment and answer any questions you might have as to the involvement of your benefit program in receiving this care. We do recommend that you contact your insurance plan to verify your benefits for treatment our physicians may recommend. We appreciate the opportunity to serve you.
- If you have an unpaid balance greater than 90 days outstanding, we have the option of declining to extend additional credit until balance is paid in full. **This would mean no additional medical appointments and treatment.**

**UN-INSURED (private pay), MOTOR VEHICLE ACCIDENT or THIRD PARTY CLAIMS:** payment in full is expected for services rendered at the time of your visit. Monthly payments by the PATIENT are required, even if the medical problem for which you are seeing the physician involves an attorney. We DO NOT wait for payment until the time that a settlement is reached.

**THERE IS NO INTEREST OR FINANCE CHARGE ON CURRENT ACCOUNTS, AFTER 90 DAYS, ALL ACCOUNTS ARE SUBJECT TO A COLLECTION FEE OF \$25.00 AND FURTHER COLLECTION ACTION WILL TAKE PLACE.**

I have read this Financial Policy and understand that regardless of any insurance coverage I may have, I am responsible for payment on my account. I understand that delinquent accounts may be assigned to a credit reporting collection service and I will be charged a \$25 collection fee. Also, if it becomes necessary to effect collections of any amount owed on this or subsequent visits the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize Cascade Orthopedics to release information necessary to secure payment. This will ensure that our responsible patients will not be penalized to cover costs incurred by those who do not pay on time.

\_\_\_\_\_  
 Signature of Patient or Responsible Party \_\_\_\_\_  
Date

\_\_\_\_\_  
 Print Patient Name DOB: \_\_\_\_\_ Account #: \_\_\_\_\_