OREGON
INTERVENTIONAL
PAIN CONSULTANTS

FINANCIAL POLICY / AGREEMENT

Patient Name:	Date of Birth:

We are committed to meeting your healthcare needs and keeping your insurance and other financial arrangements as simple as possible. In order to accomplish this in a cost-effective manner for all our patients, we ask that you adhere to our practice's financial policy. By signing below, you are agreeing to its terms.

We will bill your primary and secondary insurance carriers. As a courtesy to you, we will bill your insurance. To do this, we require that all necessary information be given to us before your visit. If you change coverage, it is your responsibility to inform us of that change **before** your scheduled visit. This will allow us to obtain necessary verification and/or authorization. Failure to do will likely result in you being entirely responsible for charges for that visit.

Insurance coverage varies from plan to plan. Depending on your individual insurance coverage, your carrier may cover come, all, or none of the services rendered to you in the Oregon Interventional Pain Consultants clinic. Regardless of your insurance coverage, you are still responsible for the bill. All health insurance plans represent a contract between you and your insurance company. Therefore, it is your responsibility to see that the insurance company makes prompt payment and to handle any disputes or questions that arise.

*****All co-payments for insurance plans are due at the time of your visit and cannot be billed. *****

"Usual and customary" rates. Our practice is committed to providing the best treatment for our patients, and we charge what we consider to be usual and customary rates. Many insurance companies have lower rate schedules which they call "usual and customary", but are in fact arbitrarily defined by them. Again, you are responsible for payment regardless of any insurance company's arbitrary determination of their own rate scale.

Cancelled or missed appointments. We require a minimum of 24 notice for cancelling appointments. Therefore, a fee of $40 for patient visits and scheduled procedures will be charged for missed visits. This fee must be paid before additional appointments can be scheduled.

I understand that Insurance/Medicare may not cover the services I may receive and I am personally responsible for payment. I have read, understood, and agree to the payment arrangements described in this Financial Policy/Agreement.

Patient Signature or Guarantor	Date
Description of Guarantor's Authority, if required:	