PATIENT FINANCIAL RESPONSIBILITY AGREEMENT

Thank you for choosing Bend Osteopathic Care, PC to assist you in your medical needs. We are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Payment Policies and Responsibilities:

- ✧ Bend Osteopathic Care, PC, will do their best to verify your insurance benefits for you if you have coverage, however this is not a guarantee of payment. We strongly encourage you to confirm your benefits prior to your first appointment.
- ✧ The patient (or patient's guardian, if a minor) is ultimately responsible for the payment of treatment and care.
- ✧ We will bill your insurance for you. However, the patient is required to provide the most current and updated information regarding insurance.
- ✧ Patients are responsible for payment of Copays, Coinsurance, Deductibles, and all other procedures or treatment not covered by their insurance plan.
- ✧ Copays are due at the time of service.
- ✧ Coinsurance, deductibles, and non-covered treatment procedures are due at time billing statement arrives.

A Copy of your current health insurance will still be taken in the following circumstances:

- ✧ If you have been involved in a motor vehicle accident, we can attempt to bill your motor vehicle insurance. There will be no co-pays, co-insurances, or deductibles if we bill your car insurance directly. Please note that we only bill **your own** motor vehicle insurance, we will not bill a third party insurance company regardless of fault. We will require the adjusters name, telephone number, billing address, and claim number.

- ✧ In the case of a "*Claimed Work Injury*", we bill Workman's Compensation directly. We will require the adjusters name, telephone number, billing address, and claim number.

- ✧ **Cancellation Policy:** Please contact Bend Osteopathic Care, PC if you are unable to keep your appointment. We reserve the right to charge ***$75 Late Fee*** for failure to call and cancel your appointment at least 24 hrs in advance**.**

(Please insert *INITIALS* in the box that you have read and agree to this policy)⟶ ☐

I, the undersigned: (Please **Tick ✓** one of the **Boxes** below)

☐ ***Do Have*** *Health Insurance* coverage OR coverage through *Workman's Compensation* or *Med Pay* through Motor Vehicle Insurance, and authorize direct payment from my insurance carrier to Bend Osteopathic Care, PC.

☐ ***Do Not*** *have Insurance* coverage and understand that I am responsible for all charges at the time of service.

You will be charged a fee of $25 if there is a returned check. In the event a check is returned, you will be asked to pay by cash or credit card for future visits.

IF IT BECOMES NECESSARY FOR THIRD PARTY COLLECTION, I AGREE TO PAY FOR ALL COSTS AND EXPENSES INCLUDING REASONABLE ATTORNEY FEES.

BEND OSTEOPATHIC CARE, PC

147 SW Shevlin Hixon Drive, Suite 204, Bend, OR 97702
Ph: 541 706-9985 | | Fax: 541 408-9853
www.BendOsteopathicCare.com

Acknowledgment:

I have read and understand the financial policy described above. I agree to pay, promptly and in full, any amounts due to Bend Osteopathic Care, PC, including co-payments, deductibles, and amounts due for non-covered services that are not payable by my insurance.

PRINT PATIENT NAME:_____

PATIENT SIGNATURE:_____

DATE:_____

PARENT/GUARDIAN must sign if patient is under the age of 18.

SIGNATURE:_____

DATE:_____

* You may request a copy of this form*

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