

Salem Women's Clinic, Inc.

FINANCIAL AGREEMENT ACKNOWLEDGEMENT-Summary of Financial Statement

AUTHORIZATION FOR RELEASE OF INFORMATION: I authorize Salem Women's Clinic to release from my medical records any information required by my insurance carrier or any person, company, or agency responsible for processing my claims for medical services.

FINANCIAL AGREEMENT: I authorize payment directly to the Salem Women's Clinic for all insurance or health plan benefits otherwise payable to me, to the extent of my bill. I acknowledge that I am financially responsible for charges not paid by my insurance/other agency and or any co-pays, deductible and/or coinsurance. I understand that if my account becomes over 90 days past due, I may be required to pay finance charges on the unpaid overdue balance. I understand my account balance is to be paid in full within 45 days of the date of service, regardless if claims are denied, unsettled or unpaid unless otherwise determined by my health plan. I further understand I am responsible for payment in full at the time of service when insurance benefits are unavailable, unless other financial arrangements have been made.

Late Fee: A late fee will be charged to your account on any past due balance over 90 days. If you are unable to pay your balance upon statement, please notify our bookkeeping department immediately at (503) 399-2402.

Initials

Insurance Co-payment Fee: Co-payments (a set amount required per office visit per your insurance company) must be paid at the time of your appointment. If you are unable to pay at check-in, there will be a \$10.00 billing fee added to the balance of your account. This fee helps defray our costs for billing small amounts.

Initials

Cancellations/No Shows: Your account will be charged a \$25.00 fee for all appointments that are cancelled with-in 24 hours of the scheduled time and when patients do not show for scheduled appointments.

Initials

After Hours Phone Calls: Your account will be charged a \$25.00 fee for all "Non-emergent" phone calls made to our providers after clinic hours. Please see our Phone Call Policy for definition of "Non-emergent".

Initials

REFERRALS: I understand that I will be financially responsible for medical services and any other charges (such as surgery, labs and x-ray) related to my treatment for a NON- Referred visit from my primary care physician.

1395 Liberty Street SE Salem, Oregon 97302

I have read the above statement and have received a detailed copy of the Financial Statement.

Patient
Signature: _____ Date: _____
(Person assuming financial responsibility)

Patient Name: _____ DOB: _____
(Please Print)

Responsible Party: _____ Relationship to
patient: _____ 10/06 kb