ENT Oregon Ear, Nose & Throat Center
541-779-7331

Clinic Financial Policy

Patient Name _____ Date of Service _____ Chart # _____

It is our office policy to inform you of our patient payment process. Please review the section below, as it is applicable to you.

1. **Patient Without Insurance (Private Pay)**
   Policy will be reviewed with you prior to your first appointment. If this hasn't been done, contact our billing department. **Payment is expected at each visit.** Payment arrangements can only be made with our billing department.

2. **Patient With Commercial Insurance**
   You are responsible for your deductible, co-pays, co-insurance, non-covered services and services considered "not medically necessary" by your insurance company. **Co-pays are expected at the time of service.** Remaining balances from deductible and co-insurance should be **taken care of within 30 days of your first statement** unless other arrangements are made with our billing department. If you or your insurance makes a payment exceeding your balance, reimbursement will be remitted to you.

3. **Patient With Medicare**
   Our office will submit your charges to Medicare and your supplement or secondary insurance. You are responsible for deductible, co-insurance, co-pays and any non-covered services.

4. **Patient With Oregon Health Plans (Open Card, Allcare, Jackson Care Connect)**
   You must inform our office immediately if you have any of these insurances.

5. **Patient With Worker's Compensation or Motor Vehicle Accident Insurance**
   You may be covered if your injury was reported and you have filed a claim. Be sure to inform our office promptly and provide the following: Insurance company name, claim number, date of injury, adjuster's name and phone number. **Patient is ultimately responsible for balance.**

I have read and agree to the Financial Policy information above that applies to me.

_____ _____
Patient or Responsible Party Signature Date

_____ _____
Person Signing on Behalf of Patient (Please Print Name) Reason Patient Unable to Sign

_____ _____ _____
Relationship to Patient Address Phone Number