West Linn Family Health Center, P.C.

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www.WestLinnFamilyHealthCenter.com

Conditions of Patient Registration

Medical Consent

- I consent to the provision of health care services at West Linn Family Health Center (WLFHC) and request my health care provider(s) to provide any care they think is necessary and consistent with my instructions.
- I understand this care may included tests, examinations, image captures, medical and surgical treatments and related anesthesia. I acknowledge that no guarantee has been made to me as to the results that may be obtained from this care.
- If the health care services I am requesting require multiple visits, I consent to all necessary routine treatment ordered by my health care provider(s) during each visit.
- I understand that the doctors at WLFHC are clinical instructors for the Department of Family Medicine at Oregon Health Sciences University and I consent to these students being involved in my care. I understand that if I am uncomfortable with this, I can ask for the student to not be involved.

Financial Agreement

In accordance with the Federal Truth-In-Lending Act we are providing the following information about our credit policy:

- Full payment on your account is due within 90 days of the first patient billing. We bill your insurance as a courtesy, but this agreement is your financial responsibility. You may request an arrangement for a payment plan if you need additional time.
- Balances extended beyond 90 days from the date of the first billing will be subject to a service charge (service charge fee schedule available upon request).
- There will be a $25.00 fee charged for all returned checks.
- There will be a $5.00 re-bill charge if insurance information is not provided accurately at the time of service.
- Co-pays are due at the time of service. If the co-pay is not paid at that time, a $20 fee will be added to the account.
- There is a $25.00 charge for no-show appointments (appointments not cancelled with 24 hours notice).

Assignment of Benefits

I hereby authorize West Linn Family Health Center to submit claims to my insurance carrier for all services rendered. I authorize the release of any medical information necessary to process these claims. I direct third party payers to issue payment directly to West Linn Family Health Center.

I understand that it is my responsibility to provide complete, accurate and timely information on my insurance coverage(s). In the event that my insurance coverage does not pay, for any reason, I understand that I will be financially responsible for the medical services received.

HIPAA

I have been offered a copy of the Notice of Privacy Practices and I have reviewed and understand the information therein.

I have read and fully understand the above information, have asked questions about anything not clear to me, and am satisfied with the answers I have received.

(Authorization valid until specifically revoked/Copy of this signature is as valid as the original)

Signature: ______________________________ Today's Date ______________

(patient or guardian signature)

Print Patient Name ______________________________ Date of Birth ______________

Drivers License #______________________________ SS#______________________

(patient or guardian) (patient or guardian)

Revised 11/02/11