Jonathan E. Greenleaf, M.D.
Richard H. Edelson, M.D.
Raymond R. North, M.D.
Kevin J. Murphy, M.D.
Sheri Cameron, PA-C
Valerie Nipper, PA-C
Lynwood Shannon, PA-C

PATIENT ACCEPTANCE OF FINANCIAL RESPONSIBILITY

I, _____, Account Number: _____

understand that any and all of the ORTHOPEDIC SERVICES AND SUPPLIES I am about to receive are
my personal financial responsibility, if it is not covered under my health plan program and I choose to obtain the services.

I understand that my **personal insurance, worker compensation or motor vehicle accident claims** do not guarantee payment.

I understand that I am responsible for obtaining any referral required by my PRIMARY CARE PHYSICIAN to a SPECIALTY PHYSICIAN as outlined in the agreement with my insurance company. This may include xrays, diagnostic procedures, and any treatment done in addition to the office visit today.

I understand that **Sports Medicine Oregon is not contracted by OHP/Welfare or United HealthCare**, and if I choose to obtain services and they are not covered, I agree to personally pay for the services I receive.

Date: _____ Signature: _____

Date: _____ Signature: _____

Date: _____ Signature: _____

Date: _____ Signature: _____

Date: _____ Signature: _____

Date: _____ Signature: _____

Date: _____ Signature: _____

Date: _____ Signature: _____

Date: _____ Signature: _____

Date: _____ Signature: _____

Date: _____ Signature: _____