SPORTS MEDICINE
OREGON

PATIENT AGREEMENT

INSURANCE

Patients are responsible to make sure the physicians of *Sports Medicine Oregon* are participating providers for their insurance plans. Please be aware that some or all of the services provided may be considered by your insurance to be "non-covered" services and may not be considered medically necessary under your plan's provisions. You will be responsible for these charges. Please check with your carrier or your insurance plan handbook for information regarding your covered and non-covered services.

You are responsible for obtaining any referrals required by your insurance plan, as outlined in the patient handout provided by your insurance carrier. You will be responsible to pay for services or penalties that are denied for lack of referral or prior authorization.

- All co-pays, deductible and coinsurance (where applicable) are due at the time of service.
- We collect a $225.00 deposit from all self-pay patients at the initial consultation with a $100.00 deposit for additional visits. Ancillary charges, such as durable medical equipment, x-rays and injections, are not included in the office visit. Self-pay patients will be billed the remaining balance or will receive refunds on any of the unused deposit.
- If you miss or cancel your appointment with less that a 24hr notice, our office reserves the right to bill you $50.00 for each no-show or late cancellation. The fee will be your responsibility and will not be billed to your insurance.
- There will be a $20.00 fee for any FMLA/Disability forms needing to be filled out. This fee will need to be paid at the time the paperwork is dropped off for the provider to complete your forms.

WORKERS COMPENSATION/MOTOR VEHICLE ACCIDENT

Patients who are being seen for workers compensation claims or a motor vehicle accident will be responsible for any services that are denied. Your claim with the insurance company does not guarantee payment.

ACKNOWLEDGEMENT & CONSENT

The *Notice of Privacy Practices* describes the uses and disclosures of health information followed by staff and other office personnel of *Sports Medicine Oregon*, and your rights regarding your health information.
You understand and agree that Sports Medicine Oregon may use and disclose your health information in order to:

- Make decisions about your care and treatment plan.
- Refer to, consult with and manage, along with other health care professionals, for your care and treatment.
- Determine your eligibility for insurance coverage, submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of your health care.
- Perform various office, administrative and business functions to support y our physicians efforts to provide you with, arrange and be reimbursed for quality, cost effective health care.

This may be in the form of written, electronic or verbal correspondence, and may include information about your health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions and similar types of health related information.

DISCLOSURE OF OWNERSHIP

Please carefully review the information contained in this notice, furnished to all patients of *Sports Medicine Oregon*. In the event you are scheduled for surgery at *Oregon Outpatient Surgery Center, LLC*., or an MRI at *Clearview MRI*, you need to know and acknowledge the following:

- Our physicians, Jonathan E. Greenleaf, MD, Richard H. Edelson, MD, Kevin J. Murphy, MD, and Conrad G. Hamilton, MD, are owners of and have interests in *Oregon Outpatient Surgery Center, LLC*.
- Our physicians, Jonathan E. Greenleaf, MD, and Kevin J. Murphy, MD, are owners of and have interests in *Clearview MRI*.
- You have the right to choose the provider of your health care services. Therefore, you have the option to use a health care facility other than *Oregon Outpatient Surgery Center, LLC* and have the right to have an MRI taken at another facility other than *Clearview MRI*.
- You will not be treated differently by your physician if you choose to obtain health care services at a facility other than *Oregon Outpatient Surgery Center, LLC*., or *Clearview MRI*.

If you have any questions concerning this notice, please feel free to ask your physician or any representative of our office at *Sports Medicine Oregon* or *Oregon Outpatient Surgery Center, LLC*.

PATIENT AUTHORIZATION

- I have read and agree to the above policies.
- I authorize payment of benefits directly to *Sports Medicine Oregon* for services provided.
- I acknowledge that a copy of the Notice of Privacy Practices will be given at the time of check-in.
- I authorize Sports Medicine Oregon to release my medical records and all information necessary for the processing or appealing of any of my medical bills.
- I acknowledge that I have read the Discloser of Physician Ownership, and understand that my physician may have an ownership interest in *Oregon Outpatient Surgery Center, LLC* and *Clearview MRI*.

My signature below certifies that I have read and agree to all the polices, authorizations and payment requirements. I understand that the stated polices apply to all services rendered.

Patient Name (print):_____ DOB:_____

Patient Signature: _____

Date: _____

OR

Guardian Representative Signature: _____

Date: _____

We welcome you as a patient and value our relationship with you!