Oregon Ear, Nose and Throat Center
Clinic Financial Policy

Patient Name _____ Date of Service _____ Chart _____

It is our office policy to inform you of our patient payment procedures. Please review the section below that is applicable to you.

_____ **1. Patient Without Insurance (Private Pay)**

Please make payment for your care at each visit. If payment cannot be made at each visit, arrangements must be made with our Billing Department prior to your appointment.

_____ **2. Patient with Insurance**

You are responsible for deductibles, copays, noncovered services, coinsurance, and items considered "not medically necessary" by your insurance company. Please pay co-payments and coinsurance amounts as services rendered. The remaining balance should be taken care of within one (1) month of notice from insurance company unless other arrangements are made with our Billing Department. If you or your insurance carrier makes payment exceeding your balance, reimbursement will be remitted. If payment cannot be made at each visit notify the Billing Department to make other arrangements.

_____ **3. Worker's Compensation Patient**

As a Worker's Compensation patient you may be covered by insurance if your injury is reported at work and verified with your employer. Be sure to inform the office personnel that your injury resulted during employment and fill out the information below. **Patient is ultimately responsible for balance.**

_____ **4. Medicare**

Our office will submit your Medicare charges to Medicare and your secondary insurance. You are responsible for deductibles, copays, and any noncovered services.

I have read and agree to the Financial Policy Information stated above that apply 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

Worker's Compensation and Personal Injury
Please Complete the Section Below

Patient's Name_____ Date of Injury_____
Contact Person_____ Contact Phone Number_____
Current Employer_____ Phone Number_____
Employer Worker's Compensation is with_____
Mailing Address_____
Claim Number_____