Lake Road Family Medicine
Financial Policy

The following financial policies have been designed to enable **Lake Road Family Medicine** to continue providing quality patient care in a cost effective manner.

Any insurance deductible amounts and non-covered services will be your responsibility. If you have any questions about the payments made by your insurer, please call our office or contact your insurer directly. **Statements are mailed out monthly and payment is due within 30 days.** Monthly statements will follow until the account is paid in full. If you have not paid your portion of the bill, or have not set up a monthly payment plan you will receive a Final Notice or Last Chance letter notifying you that your account is in jeopardy of being turned over to Collections. If the bill is not paid within the time indicated in the letter, we will have no choice but to turn the account over to a collection agency and you will be discharged from the clinic. Collection activity could impact your credit scores.

If you have questions about insurance billing, your account status, or our financial policy, please call our billing specialist who will work with you to offer personalized service to resolve billing and collection issues. **Questions: (503) 908-5880**

Credit

Lake Road Family Medicine welcomes you as a new/established patient. The following information explains our Credit Policy. Please read, sign and return to the receptionist. If you have any questions regarding any part of these policies, please do not hesitate to ask for assistance.

1. **Self Paying patients are required to make payment at time of service and will be offered a discount**.
2. Balances not covered by insurance are due within 30 days of your statement billing unless satisfactory arrangements have been made with the business office.
3. For your convenience, we bill primary and secondary insurance; however, you are responsible for paying all account balances in a timely manner regardless of discrepancies and/or disputes you may have with your insurance carrier.
4. If your medical charges exceed the annual maximum established by your insurance carrier the balance (not covered by your insurer) is your responsibility. Always call your insurer to verify your current benefits.
5. If your insurance plan requires a co-payment from you, we will collect this at the time of your visit. **CO-PAYMENTS ARE DUE AT TIME OF SERVICE.** If your co-payment is not made at time of service, you will incur a $5.00 billing fee.
6. The parent or guardian with whom a minor child lives with will be considered the responsible party for the payment of charges incurred at this facility regardless of circumstances involving, divorce, custody, etc.

We accept Cash, Checks (except new patients), VISA, MasterCard, and debit cards. As an added convenience, we can accept credit card or debit payments via the telephone. There is a $35.00 surcharge for any check returned for non-sufficient funds.

After hours

After hours paging is for emergencies only. Non-emergency pages (ie. refill requests, questions that can wait until the next business day) will be charged a fee of **$50.00**.

Referrals

If your insurance company requires a referral to see a specialist, it is the patients responsibility to contact your insurance company to see if a referral is required. If a referral is required you will need to contact your primary care physician to obtain one. If no referral is on file at the time of the appointment you will need to reschedule your appointment. If you choose to be seen that appointment will be treated as a cash pay appointment.

Cancellation Policy and Procedures

It is our policy to require 24 hour notice on all cancellations. If a patient fails to cancel 24 hours prior to the appointment, the patient is responsible for a missed appointment charge. There is a $35.00 charge for missed scheduled appointments. Please call us during our regular business hours to cancel or reschedule appointments.

After 3 consecutive “no show” appointments, the patient will be discharged from the practice.

CONTINUED ON OTHER SIDE

Insurance Plans

We participate in a variety of insurance companies. Your insurance plan is a contract between you and the insurance company. We will bill your insurance as a courtesy but ultimately, it is the patient's responsibility to check with their insurer and confirm we are participating in their plan. When changing insurance plans, we suggest you call the insurer directly as their websites are not always up to date and are sometimes confusing.

Workers Compensation and Motor vehicle claims

We do **not** accept any worker's compensation claims. We will take new motor vehicle claims on a case by case basis. You will be referred out for worker's compensation claims and difficult motor vehicle claims.

Completion of Forms and Reports

Completion of FMLA forms, disability forms etc. will incur **a minimum $35.00 fee** payable at the time of completion. You may be required to make an office visit with your provider in order for them to complete the form.

FINANCIAL AGREEMENT

The undersigned agrees that in consideration of services to be rendered to the patient, he/she assumes financial responsibility for this account under the terms and conditions listed above. Persistently delinquent accounts will be referred to an independent collection agency or small claims court, in which case you will assume the full responsibility for collection costs, including attorney and/or court fees.

I/we hereby authorize the insurer named on the "Patient Information Form" to pay directly to Jerrold L. Snow, D.O./DBA Lake Road Family Medicine, in accordance with the billing, any benefits which may apply under their policy, and hereby irrevocable assign such benefits to Jerrold L. Snow, D.O./DBA Lake Road Family Medicine, to the extent of such billing.

I/we hereby authorize the release of any and all medical information required by any insurer in connection with processing any Request(s) for benefits to which I may be entitled, and you are authorized to make such requests on my behalf. I understand that information protected by state and federal law may be requested, and I specifically consent to the release of such protected information, including/excluding information regarding treatment of HIV or mental health or chemical dependency conditions.

I have read and understand the above credit and release of information policies.

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Patient's signature (Parent or guardian if patient is a minor) Date

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Print Patient's Full Name