

WEST LINN FAMILY HEALTH CENTER, P.C.

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FINANCIAL RESPONSIBILITY, AUTHORIZATION TO RELEASE INFORMATION, ASSIGNMENT OF INSURANCE BENEFITS

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

1. 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.
2. Balances extended beyond 90 days from the date of the first billing will be subject to a service charge of 1.5% per month (annual rate of 18%).
3. There will be a \$25.00 fee charged for all returned checks.
4. There will be a \$5.00 re-bill charge if insurance information is not provided accurately at the time of service.
5. **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.

(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 _____