SOUTH TABOR
FAMILY PHYSICIANS LLP
10803 SE Cherry Blossom Drive Portland, OR 97216
Ph. 503-261-7200 | Fax 503-261-7226

CONDITIONS OF TREATMENT AND ASSIGNMENT OF BENEFITS

Patient Name: _____

Patient Date of Birth: _____

Consent to treatment: I authorize the administration and performance of all diagnostic procedures and treatment determined by the judgment of my provider to be considered necessary or advisable.

Release of Information: South Tabor Family Physicians LLP (STFP) will obtain written permission from the patient to release information except in those circumstances when STFP is permitted or required by law to release information. I agree that to determine liability for payment and to obtain reimbursement the clinic may disclose portions of my medical records to any person or corporation which is or may be liable for all or any portion of the charges, including but not limited to insurance companies, health care service plans or worker's compensation carriers. Special permission is necessary to release this information where a patient is being treated for alcohol or drug use.

Assignment of Benefits: I authorize my insurance benefits to be paid directly to STFP. I certify that all information given in applying for payment under the Social Security Act or other health insurance plan is correct and authorize verification of coverage by STFP. A copy of this authorization shall be considered effective and valid as the original.

Telehealth Visits: I authorize STFP providers to provide medical diagnostic and/or treatment services through telehealth as deemed medically necessary or advisable by my treating provider. Telehealth technologies available at STFP may include audio and video technology or telephone only sessions. I acknowledge that there are risks associated with the use of these technologies, such as equipment failure, poor image resolution and information security issues. If I have questions about telehealth, such as the capabilities and limitations of the technology, I understand that I should talk with my provider.

FINANCIAL POLICY

I**nsured Patients -** You are expected to pay the co-payment set by your insurance company when checking in for your appointment. There is a $15.00 charge for failure to pay your co-payment at check-in. You are financially responsible for all charges whether they are covered by your insurance or not. You are responsible for providing the physician's office with up-to-date insurance information and your personal billing information. Please notify us immediately of any changes with your insurance coverage. Your insurance policy is a contract between you and your insurance carrier; South Tabor Family

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Physicians LLP is not a party to that contract. Please contact your insurance carrier if you have questions regarding payment or denial of your claim.

Uninsured Patients- If your appointment was scheduled at least three days in advance, you will be provided a Good Faith Estimate indicating the expected charges for your visit. You will be expected to pay the amount indicated at the time of service. You will be billed for any additional charges or refunded if there is an over payment.

Motor Vehicle Appointments- You will need to provide the motor vehicle billing/claim information so that we may bill for your visit. We will bill motor vehicle appointment(s) after verification of claim and confirmation that all the paperwork is completed and returned.

Third Party Liability Claims- We do not bill Third Party Liability claims as proceeds are paid directly to the injured person. We will provide you with any billing information required but expect payment at the time services are provided regardless of claim status.

Statements- are sent when you accrue a personal balance, and payment is due upon receipt. There is a 1.5% per month (18% APR) finance charge on any account with a personal balance that has not been paid in full within 30 days from the date of the statement. If it becomes necessary to turn your account over to an outside collection agency, a non-refundable fee of $100.00 will be added to the account balance.

Returned checks- A $25.00 fee is charged for checks that are returned unpaid by your bank.

Form Completion- There is a minimum charge of $25.00 per item for completing forms requested by the patient. This includes but is not limited to supplemental insurance, disability and FMLA paperwork.

Missed Appointment/Late cancelation: There is a $75.00 charge for missed appointments or those not cancelled 24 hours in advance of the scheduled appointment time. We encourage you to give us the courtesy of calling and cancelling an appointment they cannot keep so that we may offer that time to another patient.

Acknowledgement: I have read this form, I understand it and if I had questions, they have been answered to my satisfaction. I certify that I am of lawful age and am legally content to consent on my own behalf as patient, or on the behalf of someone else, as indicated above.

Patient Signature:

Personal Representative Signature: