NW Preventive and Primary Care

Patient's Responsibility for Payment

As a service to our patients, NW Preventive and Primary Care (NWPPC), will submit charges for medical treatment to the patient's insurance company, where applicable. However, **the patient is primarily responsible for paying any and all medical expenses incurred at the clinic.** If you do not have any medical insurance, you will be responsible for the bill at the time of service. Monthly statements will be sent when there is a patient balance and payment is expected on a regular basis.

NWPPC *may* attempt to verify in advance that the patient's insurance company will pay for specific medical procedures. If the insurance company denies payment or will only pay a portion of the medical bill, the patient is responsible for payment of the account balance. Likewise, if the patient has not met his or her deductible under a given insurance plan, the patient will be responsible for the amount of the deductible in addition to whatever amounts the insurance company does not pay.

Quoted benefits and/or payment from insurance companies are not a guarantee of coverage. It is the responsibility of the insured to verify benefits and coverage from their insurance company.

Subject to additional fees:

- Insurance claims resubmission due to inaccurate/incomplete info provided by patients is $25
- Returned checks for insufficient fund NSF is $35 plus amount of check

If the patient is involved in a motor vehicle or liability accident, the patient is responsible for paying all medical costs, even if there is a pending lawsuit.

Contractual Agreement to Pay Medical Expenses

I understand that I am personally responsible for all medical expenses incurred at NWPPC for medical care and treatment. I agree to pay all medical expenses within 90 days from the statement date, unless other arrangements have been made with NWPPC. I understand that any bill 90 days overdue will affect my ability to schedule an appointment until it is paid.

I authorize release of all my medical information to my insurance company and I authorize payment of all medical benefits by my insurance company to NWPPC.

Signature: _____ Date: _____

Patient or Guardian Signature

Consent and Policy Agreement

730 SE Oak St. Suite K, Hillsboro, OR 97123
13112 NE Halsey St. Portland, OR 97230
Ph:503.430.1057 Fax:503.430.1085 Website: www.nwppc.com

Medical Consent: My care as a patient is directed by a licensed supervising physician. I consent to services rendered and provided to me under the instruction of supervising staff physicians.

CONSENT FOR RELEASE OF INFORMATION

Release of Information to Physician, Referring Physician, Insurer, and Professional Review Organization: I authorize release of medical and related information, including alcohol, drug abuse and mental health records obtained in the course of diagnosis and treatment to the insured's insurance carrier(s), agencies and their intermediaries or carriers, if applicable, for the purpose of obtaining care, treatment or payment for services provided or to be provided. This information may be released via first class mail, facsimile or certified courier, as applicable. Authorization may be withdrawn at any time by written notification.

Social Security numbers: Are not collected. If given, it is for the purpose of patient identification, compliance with federal and state agency reporting requirements, and billing to insurance carriers and collection needs. Disclosure of the social security number information is voluntary. If I have provided this information, I authorize release for the purpose stated above.

Controlled Substance Policy:

Our primary care providers do not prescribe long term opiates or benzodiazepines for patients. Acute prescribing is determined on a case-by-case basis, at the providers discretion. The providers do not prescribe any controlled substances on your first visit to the clinic. The prescribing of stimulants (ie: ADHD medication) is also done on a case-by-case basis and after receiving past medical records indicating your diagnosis of ADHD. If being prescribed *any* controlled substance, a controlled substance agreement form must be signed before we are able to fill said medication. These medications require paper prescriptions and a follow up visit will be required to refill all controlled substances.

Cancellation & Missed appointments Policy

Our clinic has a **24 hour** cancellation policy. If an appointment is cancelled within in 24 hours patient will receive a verbal warning. *For all appointments cancelled/ rescheduled within 24 hours of an appointment will be marked as .5. (2 cancels within 24 hours = 1 no show, please see below)* Our clinic has a **3 strike policy** for returning patients at which point services may be terminated with our clinic.

***Missed appointments**:*

For *new* patients if the 1st appointment is missed patient will receive verbal warning with explanation of cancellation policy. If the 2nd appointment is missed we will not be rescheduling patient at our clinic.

For *returning* patients if an appointment is missed patient will receive verbal warning and explanation of cancellation policy at the time of rescheduling. If a *2nd* appointment is missed patient will receive a letter from our clinic informing of missed appointment and our office policy. If a *3rd* appointment is missed we will no longer be able to schedule patient at our clinic. Patient will be sent letter notifying of termination of services with our clinic.

If we are prescribing any medication for patient with terminated services a 30 day courtesy refill will be given.

- **Arrival 10 minutes *after* an appointment time will result in required rescheduling of appointment and may also be considered a no-show or failed appointment in which a warning will be incurred. *Appointments to establish care *require* check in 20 minutes prior to appointment time.**

HIPAA PRIVACY POLICY

I have been given the opportunity to review the "HIPAA" privacy policy. **Initials** _____

I agree to the above consents, authorizations to release information, financial agreement, controlled substance, HIPAA privacy, and cancellation/missed appointments policies that apply to the medical services provided for three years from the date shown below. I have read, fully understand, and agree to the above statements.

_____

Patient Signature Date

_____

Patient PRINTED name

Parent, Guardian, Responsible Party, Legal Representative