3125 Chad Drive, Suite 100
Eugene, OR 97408
541-687-1712

Oregon Lung Specialists, LLC
Financial Statement and Patient Responsibility Policy

Printed Patient Name ________________________

In an effort to reduce confusion and misunderstanding between our patients and practice, Oregon Lung Specialists, LLC have adopted the following financial policies.

It is our office's policy to collect all co-payments when you arrive for your appointment. At times, procedures performed during your visit are not covered in the co-payment. The amount you pay at your visit may not be all you owe the doctor. Your financial responsibility will be determined after your insurance company has received a bill for all services rendered, processed the charges and paid your claim. Our physicians have made contract agreements with many insurers and health plans to accept an assignment of benefits. This means that our office will bill your insurance and will only require you to pay the copayment, coinsurance, and/or deductible amount determined by your insurance company in accordance to your health plan benefits. In the event that your health plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office. Special terms can be set up for financial hardship cases or for payment plans. Contact the Billing Office at 541-687-8304 for further information.

You acknowledge that the photo identification, insurance card and medical information provided at each visit is truthful and current. You understand that it is your responsibility to inform Oregon Lung Specialists, LLC if a change in your insurance coverage occurs prior to your appointment.

Assignment of Benefits
I herby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare or any other health/medical plan, to issue payment directly to Oregon Lung Specialists, LLC for medical services rendered to myself and/or my dependents. I understand that I am responsible for any amount not covered by insurance.

If a Primary Physician referral is required by your insurance policy to see a specialist in our practice, we ask that you ensure ALL (name of referring physician, insurance ID#, & name of employer) information has been provided, and assist in contacting your Primary Physician's office and initiate the process. If you do not have a referral in place and choose to still be seen by one of our physicians, you will be required to sign a waiver.

Social Security Number And Billing

We are granting you credit by rendering services to you before you or your insurance pays us for that service. If you choose to withhold any of the information, such as your social security number, our office requires to establish your medical record and account, then all fees for services rendered must be paid at the time of service. As a courtesy, we will submit a claim to your insurance company on your behalf.

Consent for Treatment

I understand my right to participate in my treatment process. I do hereby consent to necessary examination, procedures and/or treatments prescribed by my physician, his assistants or designee as is necessary in his/her judgment. I am also aware that by receiving treatment by an Oregon Lung Specialists, LLC physician that my health care records will be kept in a shared electronic medical record (EMR). It is possible that the records may be viewed, as needed, by other physicians for the reason of continuity of my care. I understand that my health records contain protected health information and are treated as highly confidential.

Authorization to Release Information

I hereby authorize Oregon Lung Specialists, LLC to: (1) release any information necessary to insurance carriers regarding my diagnosis and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of my lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from Oregon Lung Specialists, LLC on behalf of myself and/or dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of treatment. In the event of default, I understand that Oregon Lung Specialists, LLC may use an outside collection company if the balance on my account is not paid.

STATEMENT:

I have read and understand the financial policy of the practice, and I agree to be bound by its terms. I also understand that the practice may amend such terms from time-to-time and may not be notified until my next office visit. Finally, I agree that a photocopy of this authorization shall be considered as effective and valid as the original.

______________________________________/____________/____________________

Signature of Patient or Responsible Party Date Relationship to Patient