MOUNTAINVIEW FAMILY PRACTICE

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Office and Financial Policies

Patient initials	Item #	Policy
	1	**Prescription refills:** You are responsible to know when your medications must be refilled and to notify the office at least 48 hours before running out. Medications are refilled only at the patient visit or when requested in advance through your pharmacy. This includes all mail-order prescriptions. We cannot take weekend, walk-in, after hours, or phone call refill requests. Narcotics, anxiety, and sleep aids are only filled for 28 days.
	2	**Information:** You are responsible for providing current information such as: name, address, cellular or other phone number, email address, and insurance information. Social Security number, driver's license, or picture identification must be provided at the time of registration or as requested by the practice at any time.
	3	**Financial responsibility:** You accept financial responsibility for all charges for services rendered to you. If you are the parent or guardian accompanying the patient, you assume this liability. The office will not be involved in mediating financial arrangements between parents or guardians and are not a party in any divorce decree.
	4	**Payment methods:** We accept cash, check, MasterCard, and Visa. Checks will be processed electronically unless otherwise stated. In the future, we may ask to keep your credit card number on file with your consent.
	5	**Appointments:** Minors under age 15 must be accompanied by a parent or guardian to be seen unless special arrangements have been made with the office. We require a minimum of 24 hours (or the Friday before a Monday appointment) notice of cancellation as a courtesy to other patients seeking services. A fee of $25 will be charged for missed appointments. A pattern of missed appointments may result in discharge from the practice.
	6	**Form fees:** Our practice may charge for additional paperwork outside of the completion of the medical records and is not limited to the list below. The following fees apply and are subject to change without notice: (a) duplicate prescriptions, orders, or referrals-$25; (b) single page forms-$25; (c) multi-page forms-$50; (d) FMLA, immigration, disability, and driver's license forms-$75. Many times we need to see patients to make diagnosis prior to filling out paperwork for medical accuracy. These appointments are subject to a charge.
	7	**Medical records:** The medical chart is the property of the practice. However, copies of your pertinent medical information are available upon request and are subject to a $30 fee. Copies will be made available within 30 days of your request.
	8	**Insurance co-payments, deductibles, and coinsurance:** Insurance companies do not always pay fees and may exclude certain services from coverage. It is your responsibility to understand your insurance plan. Deductibles, co-insurance, or non-covered services are to be paid in a timely fashion according to office policies. **Copays are due at the time of your appointment** and we are obligated to collect per our contract with your insurance. If they are not paid within 24 hours after the appointment time a $10 charge will be assessed. If requested, and as a condition of service, you agree to sign an "advanced beneficiary notice" if we determine or question your insurance coverage. You accept responsibility for all such expenses even if your insurance company is billed as a courtesy.
	9	**Usual and customary:** Some insurance plans may indicate that our fees are above "usual and customary." As a result your plan may reduce our fee to an "allowed amount" before calculating payment. This practice does not recognize a specific carrier's use of these terms. As such, unless we are specifically contracted with the carrier, it is expected that you will be liable for any fees.
	10	**Slow insurance response:** You agree that if your insurance company takes more than 60 days to respond to your insurance claim, we shall consider the charges your financial responsibility and it will be your responsibility to seek reimbursement from your insurance company.
	11	**Accident & workers' compensation:** Although our office is happy to treat your medical conditions, if the cause is related to an auto or work related accident, you will be responsible for charges incurred. As a courtesy, we will bill the accident insurance if that information is made available to the office; however you are still responsible for charges incurred.
	12	**Statement policy:** Patient statements are mailed every 28 days. Payments are due by the statement due date. You understand that if we participate with your insurance company the sending of a statement may be delayed until your insurance responds to a claim for services. Such a delay can take months. You understand that such a delay does not alter our policy of patient financial responsibility and you will be liable for all service fees. An interest charge of 1.5% per month will be assessed on balances 90 days or older as allowed by Oregon law.
	13	**Collection and bank fees:** Accounts more than 90 days old are subject to transfer to an outside collection agency unless payment arrangements have been made through the billing department. Fees may be assessed by the collection agency and by banks for checks that do not clear. A $35 fee will be assessed by the office for any returned checks.
	14	**Patient discharge:** The practice reserves the right to discharge a patient for any reason. Please note that discharges may occur for failure to meet your obligations under this document. In addition, because of care quality considerations, the practice may discharge you for failure to comply with a treatment plan(s) as outlined by your practitioner, repeated missed appointments, and failure to comply with a medication contract.
	15	**Insurance claims:** If applicable, our office will submit insurance claims. You agree to allow our practice to "accept assignment" of benefits and receive payment directly from your insurance company. In the event your insurer sends payment for a claim from our office to you directly, you agree to endorse the payment to our practice in fulfillment of any amounts due within 10 days of postmark.

I have read and understand all the terms of this policy and by my initials and my signature below, I attest that I fully understand each item and agree to the terms above.

Signature _____ Date _____

Patient name _____ Account # _____

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