



## **Southern Oregon Internal Medicine**

*A Rogue Valley Physicians, P.C. Clinic*

### **Financial Policy**

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Thank you for choosing Southern Oregon Internal Medicine for your health care needs. The following is a statement of our Financial Policy which we require you to read and sign prior to your visit with us.

#### **REGARDING YOUR INSURANCE**

It is not possible for a medical practice to become familiar with the details of every health insurance plan it encounters. It is the responsibility of the patient to be aware of what is covered and what is not covered by your insurance, and how much the patient responsibility for services will be. We will submit insurance claims as a courtesy to our patients with insurance, and will help you in every way possible to obtain your maximum insurance benefits. However, you are responsible for our charges. We ask that you pay any deductible, co-pay and balance owed at the time of service. Please remember that we can only estimate the amount to be paid by an insurance company as they make payments based on their fee schedule. Their fee schedules may differ from our charges. While we attempt to help you in every way possible to obtain your maximum allowable insurance benefits, the insurance contract is between you and your insurance company and does not replace your responsibility for your account. If your insurance company has not paid your claim within 45 days, we will ask you to pay the balance in full. We will not be calling your insurance prior to your visit to verify your coverage.

#### **SECONDARY INSURANCE**

Having more than one insurer does not necessarily mean that your services are covered at 100%. We may bill your secondary carrier as a courtesy. You are responsible for any balance after insurance(s) has cleared.

#### **USUAL AND CUSTOMARY RATES**

Our practice is committed to providing the best care for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

**Southern Oregon Internal Medicine**  
2900 Doctors Park Drive  
Medford Oregon 97504  
Phone: 541-282-2200 Fax: 541-282-2237  
A Rogue Valley Physicians, PC Clinic  
[www.RogueValleyPhysicians.com/SOIM](http://www.RogueValleyPhysicians.com/SOIM)

## **FOR PATIENTS WITHOUT INSURANCE**

We ask that our patients that do not have insurance pay at least ½ of their charges at the time of service. The remainder of this balance must be paid in 2 equal monthly payments. Special arrangements may be made with the advance approval of the billing department. Please let the receptionist know if you need to speak to our billing staff.

## **OREGON HEALTH PLAN PATIENTS**

If you are an Oregon Health Plan/Medical Card patient, we require that you show your current medical card before each visit and that you are currently assigned to the appropriate physician. We will re-schedule your appointment if you fail to comply with this policy and do not present with your current card. We are unable to call your insurance prior to your visit to verify your coverage.

## **SERVICE CHARGES**

A fee of \$25.00 will be assessed to your account for any check returned due to non-sufficient funds. A fee of \$20.00 may be assessed to your account for a missed appointment.

## **WE ACCEPT PERSONAL CHECKS, MONEY ORDERS, VISA, MASTERCARD, AMERICAN EXPRESS, DISCOVER AND CASH**

Thank you for your attention to our financial policy. Please let us know if you have any questions or concerns.

**I have read the Financial Policy. I understand and agree to the terms of this Policy. In addition, I authorize Southern Oregon Internal Medicine to release any medical information necessary to process a claim. I hereby assign payment directly to Rogue Valley Physicians, PC all payments due from my insurance company. I understand that I am financially responsible for the charges and should it become necessary to collect monies in court, all court costs and attorney fees are the responsibility of the patient.**

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**Patient (or Legal Guardian) Signature**

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**Date**

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