Rogue Valley Physicians, P.C.
FINANCIAL POLICY

Thank you for choosing Groskopp and Ryland as your health care provider. The following is a statement of our Financial Policy which we require you to read and sign prior to your visit with us.

- ***REGARDING COMMERCIAL INSURANCE***

It isn't easy for an office to become familiar with the details for every health insurance plan it encounters. It is the **Responsibility of the patient/legally responsible adult**, not the medical office to know your benefits, what is covered, what is excluded and how much will be the patient responsibility. We will submit insurance claims as a courtesy to our patients with insurance. 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 Call To Verify Insurance 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.

- ***PRIVATE PAY***

We ask that our patients without insurance pay a minimum of ½ of their charges at the time of service. The remainder of this balance must be paid in 3 equal monthly payments. Special arrangements can be made with the advance approval of the clinic manager or billing department.

- ***MEDICAID/OHP PATIENTS***

Oregon Health Plan/Medical Card patients, this office **requires** 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 the current card. ***We Will NOT Call To Verify Insurance Coverage***

- ***DIVORCE DECREES***

This office is NOT a party to your divorce decree. The financial responsibility for minors rests with the **accompanying** adult.

- ***MINOR PATIENTS***

The adult **accompanying** a minor (or guardians of the minor) is responsible for full payment of visit attended. The responsibility for payment remains that of the parent/guardian whose signature is on file even after the child is no longer a minor until this agreement has changed in writing.

- ***SERVICE CHARGES***

We reserve the right to apply a finance charge in the amount of 1.5% per month or 18% annually to all account balances after 90 days as allowed by state law. 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, DISCOVER AND CASH

Thank you for understanding 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:

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Patient Name

____ ____________________
Signature of Parent or Guardian **Date**