Oregon Heart Center P.C.
Cardiac & Arrhythmia Services

610 Hawthorne Ave SE, Ste 110
Salem, OR 97301
Ph: 503-814-4440

Payment Policy

PATIENT RESPONSIBILITY:

- You are responsible for all charges resulting from treatment provided by ***Oregon Heart Center***. We bill most insurance carriers; however, primary responsibility for the account is yours. Any remaining balance owed by you is due when you receive your first bill, unless other financial arrangements are made. We do allow for payment arrangements to be made, but we do charge a $5.00 per month billing fee for all accounts after 90 days.
- **Your co-payment is always due at the time of service**; **if you fail to pay at the time of service you will be charged a $5.00 fee to cover the cost of sending a statement to you.** You are responsible for knowing what the amount of your copay is, and for assuring that it is collected at each visit. The fee will be assessed for any copay that your insurance assesses you that was not paid at the time of service.
- If we find it necessary to send your account to collections, you will be required to make a payment at the time of each of your next visits with us or you may be released as a patient. If you DO NOT pay the required amount each visit you will be assessed a $20.00 fee for each visit.

INSURANCE BILLING:

- Please bring your current medical card with you to each appointment as we require a copy of your insurance card to be on file with our office. This is to ensure accuracy.
- It is your responsibility to provide current, accurate insurance billing information. If your insurance information changes, please provide the new insurance information immediately so that we may insure all of your charges are billed to the correct insurance company. If your insurance coverage is not in effect at the time you receive care, or if your plan does not cover the services that you receive, you will be responsible to pay the charges in full.

RETURNED CHECKS:

- It is our office policy to charge a $ 28.00 fee for checks that are returned regardless of the reason.

Authorization to Release Information:

- In obtaining payment for services, I authorize ***Oregon Heart Center***, to furnish information from my medical record to any company that may be responsible for payment of all or part of my charges.
- If I have been referred by, or am being referred to another healthcare provider, I authorize ***Oregon Heart Center*** to release my medical information to this provider for continuing care.
- I also assign ***Oregon Heart Center*** all payments to which I am entitled for medical expenses related to the services reported herewith. I understand I am financially responsible for all charges whether covered by insurance or not.

I, OR MY APPOINTED AGENT, HAVE READ, FULLY UNDERSTAND AND AGREE TO THE ABOVE STATEMENTS. I HAVE RECEIVED A COPY OF THIS INFORMATION.

_____ _____ _____
Patient Name (Please Print) Patient's Signature Date

IF PATIENT IS UNDER THE AGE OF 18 YEARS, OR IS OTHERWISE UNABLE TO SIGN, COMPLETE THE FOLLOWING:

Patient is _____ year(s) of age or is unable to sign because: _____

_____ _____ _____
Signature Relationship to Patient Date

Sign Below if Disclosure of Information is NOT Authorized:
Therefore, I agree to pay for costs of all treatment and services personally.

_____ _____ _____ _____
Signature of Guarantor Date Signature of Patient Date

HIPAA and NOTICE of PRIVACY PRACTICES

By signing below, I acknowledge that I HAVE RECEIVED, OR WAS OFFERED, a copy of the Notice of Privacy Practices.

_____ _____ _____
Patient (or Legal Representative) Signature Date Relationship to Patient, if signed by Legal Representative