

16463 S.W. Boones Ferry Road
Lake Oswego, OR 97035

CREDIT POLICY

As a service to our patients, we would like to outline our policy regarding the payment for services.

1. Payment for the first office visit is expected on all new patients. Twenty-four(24) hour notice of cancellation is required. There will be a charge of \$50.00(not covered by insurance) after 2 no shows.
2. Payment on established account is due every 30 days by Health Insurance or the responsible party (patient, parent or legal guardian). Blue Cross, Medicare, OMAP and Workman's Compensation are billed routinely by this office. All insurance is billed on a routine basis. Although we are billing these insurance companies as a courtesy to you, we hold you responsible for your account.
3. If the problem for which you are seeing the doctor involves litigation, such as may result from an automobile accident, be advised that we do not wait for payment until the litigation is settled.
4. Your signature authorizes us to contact references in case it becomes necessary to locate you.
5. We encourage you to contact our business office if you have any questions regarding your account.
6. All credit balances may be held as credits against future services rendered unless credit refunds are specifically requested.

I HEREBY AUTHORIZE THE ABOVE DOCTOR(S) TO FURNISH THE INSURED'S INSURANCE COMPANY ALL INFORMATION WHICH SAID INSURANCE COMPANY MAY REQUEST CONCERNING MY PRESENT CLAIM. I HEREBY ASSIGN TO THE DOCTOR(S) ALL MONEY TO WHICH I AM ENTITLED FOR EXPENSE RELATIVE TO THE SERVICES PERFORMED FROM TIME TO TIME BUT NOT TO EXCEED MY INDEBTEDNESS TO SAID DOCTOR(S). I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO SAID DOCTOR(S) FOR CHARGES NOT COVERED BY THE ASSIGNMENT.

RESPONSIBLE PARTY'S SIGNATURE	PATIENT'S SIGNATURE	TODAY'S DATE	
PATIENT	(FIRST NAME, MIDDLE NAME, LAST NAME)	DOB:	AGE:
ADDRESS:	CITY	STATE	ZIP
STREET			
SSN:	DRIVERS LICENSE #	PHONE	
MARITAL STATUS:			
OCCUPATION	EMPLOYER		
ADDRESS:		PHONE	
RESPONSIBLE PARTY	ADDRESS:	PHONE	
SS#	EMPLOYER	PHONE	
SPOUSE'S NAME	ADDRESS:	PHONE	
SS#	EMPLOYER	PHONE	
NEAREST RELATIVE NOT LIVING WITH YOU: NAME		RELATIONSHIP	
ADDRESS:		PHONE	
STREET	CITY	STATE	ZIP

PERSON TO NOTIFY IN CASE OF EMERGENCY OTHER THAN IMMEDIATE FAMILY

NAME	ADDRESS(STREET, CITY, STATE, ZIP)	PHONE
NAME	ADDRESS(STREET, CITY, STATE, ZIP)	PHONE

HEALTH INSURANCE – SUBSCRIBER'S NAME

COMPANY	ID #	GROUP #
WHO REFERRED YOU TO US?		