

**Olson Memorial Clinic
16463 Boones Ferry Rd 300
Lake Oswego, OR 970035**

CREDIT POLICY

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

1. Twenty-four (24) hour notice of cancellation of appointment is required. There will be a charge of \$100.00 (not covered by insurance) for a no-show physical exam. There will be a charge of \$50 (not covered by insurance) after two no-shows for other office visits.
2. Payment for the first office visit may be expected for all new patients. Payment on established account is due every 30 days by Health Insurance or the responsible party (patient, parent or legal guardian). All insurance companies are billed on a routine basis by this office. *Although we bill these insurance companies as a courtesy to you, you are responsible for your account.*
3. If the issue 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 to contact references listed below if it becomes necessary to locate you.
5. All credit balances may be held against future services rendered unless credit refunds are specifically requested.
6. We encourage you to contact our business office if you have any questions regarding your account.
7. 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 RELATED TO THE SERVICES PERFORMED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO SAID DOCTOR(S) FOR CHARGES NOT COVERED BY THE ASSIGNMENT.

_____/_____/_____
Patient's signature Today's Date

Name: _____ DOB: _____/_____/_____
First Name Middle Name Last Name

Address: _____
Street City State Zip

Phone: (home) _____ (cell) _____ SSN: _____

Occupation: _____ Employer: _____ Work Phone: _____

Spouse's Cell: _____ Spouse's Work Phone: _____

PERSONS TO NOTIFY IN CASE OF EMERGENCY OTHER THAN IMMEDIATE FAMILY:

Name: _____ Phone: _____

Name: _____ Phone: _____

Referring Physician: _____