CEDAR CREEK INTERNAL MEDICINE, PC

PAYMENT POLICY AGREEMENT

At Cedar Creek Internal Medicine our primary responsibility is to assist our patients by delivering optimum healthcare. By establishing a Payment Policy with our patients we hope to avoid any unforeseen financial misunderstanding. This allows us to offer the maximum use of our time and energy maintaining your good health.

Your insurance company may require you to make a co-payment for each office visit. If your co-payment is not made at the time of each visit a service charge of $20.00 will be added to your account. For your convenience we accept cash, personal check, money order, cashier check, Visa or MasterCard.

All accounts are due and payable within 30 days of services rendered. Please contact our Billing office at 503-605-9230 if you would like assistance arranging payments.

You must bring ***your current insurance card(s)*** with you to your appointment. If you fail to produce ***your current, valid, insurance card(s)*** you will be billed directly for services received on the date of appointment until you can produce physical proof of ***your insurance coverage.*** If you no longer or do not have insurance you will be asked for a deposit for your visit of **$50 if you are a current patient and $150 if you are a new patient.**

Even though we bill your insurance you will receive a monthly statement. Please bear in mind that you are ultimately responsible for any monies owed on your account regardless of insurance coverage. It is our practice to charge for completion of insurance forms and letters written on behalf of our patients requested by our patients.

Delinquent account may be assigned to a collection agency. If my account is assigned to a collection agency, I agree to pay any amount(s) owed on this and subsequent visits. I agree to pay all costs and expenses incurred.

My signature below acknowledges that I have read and understand the ***Payment Policy***. My signature below also authorizes assignment of benefits from any relevant insurance company or companies for visits to Cedar Creek Internal Medicine. Furthermore, I understand that I am financially responsible for all incurred charges that are not covered by my insurance. I hereby authorize Cedar Creek Internal Medicine to release requested information that pertains to my visits to my insurance company or companies.

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Patient Name

_____ _____

Patient Signature Date

Revised 08/13/08