



Financial Policy

Thank you for choosing Willamette Pain and Spine to assist you with your health care needs. We strive to provide you with the best care possible, and, in return, we ask that you assist us not only in monitoring your health care, but also by paying for our services in a responsible and timely manner.

The following is a statement of our financial policy. Our office requires that each patient read and sign a copy of this policy before we provide any treatment. Therefore, please read through this statement carefully and feel free to ask us any questions you may have relating to our policy before you sign:

- **Insurance cards must be presented at each and every visit.**
- **We do not accept personal checks. We do not accept personal checks or American Express, other payments accepted, Cash, Visa, Discover and MasterCard.**
- **It is your responsibility as the insurance holder to know your benefits. As a specialty office, not all services provided by our office are covered by every plan, therefore any service determined to not be covered will be patient responsibility.**
- **According to your insurance plan, you are responsible for any and all copayments, deductibles and coinsurances, are due at the time of service.**
- **If our providers do not participate in your insurance plan or you have no coverage, payment is due in full at time of service.**
- **All current and prior patient balances including coinsurance and deductibles are due at time of service; appointments will be rescheduled if payment is not collected. Please call your insurance company if you have any questions related to coinsurance and deductibles.**
- **An upfront service charge of \$50 is required for filling out and processing any paperwork, if an appointment is not required by the provider, including, but not limited to:**
 - **Disability**
 - **FMLA**
 - **Workers Compensation**
 - **Forms will not be processed until payment is received in full**

Missed Appointments: You will be charged for missed appointments; follow-up appointments that are not cancelled at least 24-hours in advance, is **\$25.00**. A New Patient Appointment or Procedure that is not cancelled or missed with less than 24-hours advance notice will be **charged \$50.00**. **If you are late 10 minutes or more for your appointment you will be rescheduled and charged a \$25 missed appointment fee.** Three or more missed appointments are grounds for termination of the patient/provider relationship.

Patient Responsibility balances over 120 days will be discharged from care.

Print Name: _____ **DOB:** _____

Signature: _____ **Date:** _____