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*Rehabilitation Medicine
Associates, PC*

FINANCIAL STATEMENT

As a courtesy to our patients, we will bill insurance companies for services incurred in our clinic. It is the responsibility of the patient to provide correct insurance information or Workers Compensation information. If you have any questions regarding your benefits, please contact your insurance company. Please note that all Workers Compensation Patients must also provide private insurance information.

PRIVATE MEDICAL INSURANCE:

Your insurance policy may require a deductible or co-payment and may not include all charges. *Co-payments are due at time of service*

WORKER'S COMPENSATION and MOTOR VEHICLE INSURANCE:

We will bill Worker's Compensation insurance and motor vehicle insurance. In the event claims are denied or your Personal Injury Protection (PIP) becomes exhausted, we will bill your private medical insurance. If there is no private medical insurance, the patient is responsible for all charges incurred in our clinic. ***OUR POLICY: We do not wait for settlement on charges incurred in our clinic. The patient is responsible for any and all unpaid charges.***

PRIVATE PAY PATIENTS:

Private pay patients will be required to make a deposit before services are rendered.

New Patient: \$100.00

Established Patient: \$50.00 (with a positive payment history)

Statements are sent for any and all unpaid balances on a monthly basis. ***Payment is due upon receipt.*** If you cannot make the payment in full, please contact our business office for payment arrangements.

Appointment Cancellation, "No-Show", and Late Policy:

- All patients who "No Show," or cancel with less than 24 hours notice, or arrive too late to be seen, with the physicians authorization, will be able to reschedule 1 additional time. If the patient is in a Worker's Compensation case, the adjustor will be notified.
- All patients who "No Show," or cancel with less than 24 hours notice, or arrive too late to be seen for **two** appointments, with little exception, will be discharged from the practice. Re-consideration of discharge may occur with extenuating circumstances and physician authorization.

I hereby agree to full responsibility for all expenses incurred by or on the account of the patient, and hereby assign to Rehabilitation Medicine Associates any and all insurance benefits due to me to the full extent of my financial obligation to said clinic.

I hereby authorize Rehabilitation Medicine Associates to release to my insurance company any information required in the course of my examination and treatment.

Signature _____ Date _____
Patient (Parent/Guardian if disabled or a minor)

Print Name _____

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