



PATIENT FINANCIAL POLICY

Print Patient Name: _____ Date of Birth: _____

Thank you for choosing Willamette Urology as your healthcare provider. We are committed to providing you with quality medical care. Please understand that payment for your bill is considered part of your care plan. We ask that you read and sign this Patient Financial Policy at your visit today.

1. Insurance is billed as a courtesy when you provide us with current insurance information and sign our Acknowledgment and Consent form. If you do not present a current insurance card at the time of visit, you will be billed directly for the provided services. Please be advised that insurance is a contract between you and your insurance carrier. You are responsible for payment of your account.
2. It is important for you to understand that most insurance policies will not cover all of our charges. We may require you to make some type of payment before services can be provided. Typically, the payments are called co-payments, co-insurance or deductibles. These amounts are put in place by your insurance carrier, not our office. We will do our best to notify you ahead of time whenever possible. Any amounts quoted prior to the services being provided are only estimates and may be adjusted once the services have been provided, and insurance payments received.
3. Referrals and prior authorizations may be required by your insurance policy. We will do our best to obtain these; however, it is your responsibility to ensure these are in place prior to receiving services
4. In the absence of insurance coverage, a \$100 deposit is required at time of service. If you are unable to pay this deposit, upon request, a Financial Assistance Application will be given / mailed to you. Completed applications will be reviewed and you will be notified in writing of any amount the physician will write off. Reduction in your financial responsibility will be based on your ability to pay and not your willingness to pay. You have up to 90 days from the date of service to complete your application.
5. If you have a balance due on your account, we will send you a bi-weekly statement. The balance on your statement is due and payable when the statement is issued and is past due if not paid within 30 days. If you are unable to pay in full, you may enroll in an in-house payment arrangement up to three months, which will have a standard minimum of \$25.00. Dishonored checks will be charged \$35.00.
6. If we have to refer your account to a collection agency, you agree to pay all collection costs that are incurred. If we have to refer collection of the balance to an attorney, you agree to pay all attorney fees, including court costs.
7. You grant permission and consent to Willamette Urology and its agents, assignees, and contractors (which may include third-party debt collectors for past due obligations):
 - (1) to contact you by phone at any number associated with you, whether provided by you or obtained on its own;
 - (2) to leave messages for you and include in any such messages the amounts owed by you;
 - (3) to send you text messages or emails using any email address or phone number associated with you, whether provided by you or obtained on its own; and
 - (4) to use prerecorded/artificial voice messages and/or an automated telephone dialing system (an auto-dialer) as defined by the Telephone Consumer Protection Act in connection with any communications made to you regarding your account.

8. You agree to provide updated contact information in an effort to avoid unintended disclosures of your information, and you accept and acknowledge that Willamette Urology and its agents, assignees, and contractors (which may include third-party debt collectors for past due obligations) will treat any email address or phone number obtained as your private email or phone number that is not accessible by unauthorized third parties.
9. You understand that communications may result in charges to you by your mobile service provider and are not encrypted.
10. You understand that communication attempts will be made to your cellular phone during permitted calling hours based upon the time zone affiliated with the cellular phone number provided unless notified otherwise.
11. You understand if this account is submitted to a collection agency or attorney, is litigated in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

I HAVE READ THIS FINANCIAL POLICY AND UNDERSTAND THAT REGARDLESS OF ANY INSURANCE COVERAGE I MAY HAVE, I AM RESPONSIBLE FOR PAYMENT OF MY ACCOUNT. I UNDERSTAND THAT DELINQUENT ACCOUNTS WILL BE ASSIGNED TO A CREDIT REPORTING COLLECTION AGENCY. IF IT BECOMES NECESSARY TO PROCEED WITH COLLECTIONS, THE UNDERSIGNED AGREES TO PAY FOR ALL COSTS AND EXPENSES, INCLUDING REASONABLE ATTORNEY FEES.

Patient / Guarantor Signature

Date

Print Patient / Guarantor Name

Relationship to patient if not the patient