Financial Responsibility and Assignment of Insurance Benefits

Hillsboro Pediatric Clinic LLC
503-640-2757
FAX 503-640-9753

Financial Policies of Hillsboro Pediatric Clinic LLC (HPC)

1. **Co-Pays:** You must pay your co-pay at the time of service as required by your insurance company.
2. **Accepted forms of payment:** We accept cash, check, MasterCard, Visa, Discover and debit cards.
3. **Discounts:** Cash discounts will be given for patients without insurance if you pay in full for services on the day of the visit: 10% (ten percent) if paid by cash or check and 5% (five percent) if paid with a credit or debit card. If your check is returned NSF by the bank, the 10% discount will be reversed and you will be billed for the full fee.
4. **NSF Charges:** A returned check for non-sufficient funds will result in a charge of $25.00. This fee is due and payable upon receipt of our bill.
5. **Financial Hardship:** If you are going through a financial hardship and cannot pay your bill, it is your responsibility to contact our Billing Department to inquire about financial assistance offered by HPC.
6. **No Insurance/Self Pay:** If you do not have health insurance or proof of coverage, we require a $125.00 deposit before your first visit, and a $50.00 for each visit after that. These deposits will be applied to our bill for medical services; and any remaining balance will be billed to you or any overpayment will be refunded to you. If you do not have insurance, the Oregon Vaccines for Children program will cover the cost of vaccines. You will be billed for the small cost of administering the vaccine.
7. **Insurance billing:** You are responsible to know your insurance benefits, including what is and is not covered. We will bill your primary insurance company when you provide us with current and complete information. By signing below, you agree you are responsible to pay for all services that your insurance has denied and for amounts not paid under this assignment, including your health insurance deductible, coinsurance and copays.
8. **Secondary insurance billing**: As a courtesy to you, we will file a secondary claim once for each visit.
9. **Statements:** Even though an insurance claim may be pending, you may receive a statement if your account has an outstanding balance. HPC cannot accept responsibility to collect your insurance claim or to negotiate a settlement on a disputed claim.
10. **Payments on Account Balances:** You are responsible for the timely payment of your account. All unpaid amounts are due and payable within 15 (fifteen) days of the statement date and no later than 60 (sixty) days after the date of service, regardless of insurance status or disputes.
11. **Oregon Health Plan:** If we are unable to verify your coverage, you will be given the option of signing a waiver accepting responsibility of any balance accrued for that visit.
12. **Collections:** Accounts assigned to a credit reporting and collections service will be charged a $50.00 collection fee. Discounts previously allowed will be reversed and you will be billed the full fee. Should the account be referred to an attorney for collection, the undersigned shall also pay reasonable attorney's fees and collection expense.

I, as the responsible party, hereby authorize payment directly to HPC for health care benefits. This authorization is effective for any providers for whom HPC is authorized to bill in connection with its services. I understand that under this agreement I am financially responsible for all amounts due. I acknowledge and understand that bodily fluids or tissues collected by HPC will be sent to an unaffiliated lab and that I will receive a separate bill from them for tests and interpretations. I have read, fully understand and agree to the above statements.

By signing below, you agree you have read this document and agree to the statements above. You will receive a copy of this information.

Parent or Legal Guardian Signature: _____ **Date:**_____

Name: _____ ***Relationship to Patient (or self)*:** _____

Patient Name:_____ **DOB:** _____