FALL CREEK
INTERNAL MEDICINE

2160 NE WILLIAMSON COURT
BEND, OREGON 97701

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OFFICE POLICY AGREEMENT

Thank you for choosing Fall Creek Internal Medicine, LLP for your health care. We are committed to providing you with quality, personal health care, and appreciate your commitment to adhere to this **Office Policy Agreement.** Agreement with this policy is required for all medical care.

HOURS: (visits by appointment only)

- **Office hours: Monday- Friday 8:00 am to 5:00 pm**
- **Telephone hours: Monday – Friday 8:00 am to 4:30 pm**
- **Closed for all recognized US holidays**

AFTER HOURS:

- On call Physicians are available for after hours **urgent** phone consultations**.**

APPOINTMENTS: Please arrive at least 15 minutes early for routine medical appointments. For any annual wellness visits and new patient appointments arrive at least 20 minutes before your scheduled appointment to review and complete the necessary paperwork involved in your care. ***PLEASE DO NOT WEAR PERFUME, COLOGNE OR ANY FRAGRANCES TO YOUR APPT ***

As a courtesy to other patients, we request you arrive on time. If you arrive later than your designated arrival time, you may be asked to reschedule.

MISSED APPOINTMENTS: If you are unable to keep your scheduled appointment please call our office at least two business days prior to your appointment and reschedule. Broken appointments prevent us from caring for others who could have been seen in the time set aside for you. ***If you miss or cancel your appointment with less than a 24hr notice, our office reserves the right to bill you $50.00 for each no-show or late cancelation. The fee will be your responsibility and will not be billed to your insurance.***

TELEPHONE CALLS/MESSAGES: When you call during regular business hours please be ready to provide your name, date of birth and phone number. If you reach our voicemail system please leave a brief message with your full name, date of birth and the best phone number to reach you.

AFTER HOURS/EMERGENCIES: ***If it is a life threating emergency please call 911 first***. Otherwise please call the office and a message will guide you to the Doctor on Call. Please be ready to state your name, date of birth, phone number and what symptoms you have.

PRESCRIPTION REFILLS: Please contact your pharmacy directly for a prescription refill. The pharmacy will then contact us via fax requesting the prescription refill. Please allow 48 hrs for us to process refill requests. Refills for controlled medication require 3 business days. Contacting the pharmacy and then the office will not speed up this process, it only duplicates request and slows the refill process. The patient is responsible for advising the pharmacy of their preference of using name brand or generic prescriptions. FCIM does not have any control over pharmaceutical tiered pricing. ****PRESCRIPTION REFILLS ARE NOT EMERGENCIES**.** Our on call physician will not process refill requests until the next business day.

PATIENT REGISTRATION: We ask that all our patients fill out a new patient registration/or review the current information we have on record once a year and provide valid insurance card.

HIPAA: It is required that all patients fill out a HIPAA form on a yearly basis. This form gives you the opportunity to list the individual(s) with whom you give us permission to discuss and/or release your medical information. If during the year you have changed your list of individual(s) to whom you authorize release, please fill out a new HIPAA form. If you have listed restrictions for the release of your medical care, your physician will review and discuss this with you as this may restrict continuity of your care and other medical needs that are part of our health care commitment.

MEDICAL RECORD: In accordance with Oregon law, Fall Creek Internal Medicine, LLP requires a HIPAA compliant written request for the release of medical records. We use DataFile Technologies to fulfill medical record requests. Any requests made for ***transfer of care or for personal review*** will be billed up to $25.00 from DataFile Technologies and payment is due prior to the release of requested records.

DIAGNOSTIC/LAB STUDIES: If you would like a copy of your lab results or a diagnostic study ordered by our physicians, you will need to complete our Personal Use Only Medical Record Release form. You can request this from your physicians' medical assistant. We require the Personal Use Only Medical Record Release to be reviewed and signed by the patient on a yearly basis. You may also request a copy of you lab results when you are at the lab, per their policy.

I have read, understand, and agree to comply with the terms of FCIM Office Policy. I understand that it is my responsibility to read the policy I have been offered and if I have any questions or need clarification I can contact the Clinic Administrator Monday- Friday 8:00am-4:30pm.

_____ _____

Patient Signature (or responsible party for patient) Date

COPY AVAILABLE UPON REQUEST

_____

Printed Name

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FINANCIAL POLICY AGREEMENT

INSURANCE: We contract with the major Oregon companies and bill most insurance companies. Knowing your insurance benefits – including eligibility, covered benefits and medically necessary procedures is ***your*** responsibility; please contact customer service at your insurance company for questions regarding your coverage. ***You are responsible for any charges not covered by your plan*.**

- **PROOF OF INSURANCE:** All patients must furnish valid and up-to-date proof of insurance coverage. If you provide false or expired insurance information you will be responsible for the balance of the claim. ***Please notify us of any changes in insurance coverage as soon as possible.*** Insurance denials for termination of coverage will be automatically billed to you.
- **CO-PAYMENTS AND DEDUCTIBLES:** All co-payments must be paid at the time of service. By contractual law your insurance company requires us to charge for, and you to pay for, all required co-payments, co-insurances, deductibles and non-covered services.
- **CLAIM SUBMISSION:** We will submit claims to your insurance and assist you in any way reasonable to help get your claim paid. Your insurance company may need you to supply information directly to them. It is your responsibility to comply with their request in a timely manner. Your insurance is a contract between you and your insurance; not us and your insurance. Please be aware the balance of your claim is your responsibility to pay whether or not your insurance company has paid.
- **REFERRALS:** If your managed care plan requires approval or authorization for referrals to a specialist, radiological imaging, medical facility care, etc., it is ***your*** responsibility to inform the office of this requirement ***prior*** to referral. We require 72 hours notice to facilitate a referral request and cannot issue retroactive referrals.
- **OUT-OF-NETWORK CARE:** Please be aware that you have an option to seek care from Physicians even though they are not participating in your network. In this situation, your out-of-pocket expense will be greater. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance.
- **LABS/DIAGNOSTICS/PHARMACIES:** **PLEASE NOTE** Lab work, X-rays, referrals and all pharmacies including mail order pharmacies are **NOT** billed by Fall Creek Internal Medicine, LLP. You are responsible for any and all charges/costs associated with those outside organizations for making payment arrangements with them. We recommend you check with those agencies regarding costs and consult your insurance policy for your benefit information.
- **WORKERS COMPENSATION / MOTOR VEHICLE ACCIDENT:** FCIM provides treatment for established patients for both work-related injuries and automobile accidents. The patient is responsible for providing us with timely billing information for treatment of these injuries. Patients who are being seen for workers compensation or for a motor vehicle accident claim, will be responsible for any services that are denied. Your claim with the insurance company does not guarantee payment.
- **MEDICAL RECORDS:** We use DataFile Technologies to fulfill medical record requests. Any requests made for ***transfer of care or for personal review*** will be billed up to $25.00 from DataFile Technologies and payment is due prior to the release of requested records.
- **MISSED APPOINTMENTS:** If you miss or cancel your appointment with less than a 24hr notice, our office reserves the right to bill you ***$50.00 for each no show or late cancelation***. The fee will be your responsibility and will not be billed to your insurance.
- **PATIENT BALANCE:** After your insurance processed your claim, we will mail you a patient balance statement. Payment in full is due upon receipt of this statement. If you have any questions or dispute the balance it is your responsibility to contact our billing office within 30 days. Past due balance are subject to collections and may be referred to a credit bureau and/or collection agency. If you are not able to pay the balance due in full, you must contact our billing office to discuss a payment schedule.
- **RETURNED CHECKS:** The charge for a returned check is $27.00 payable by cash, debit/credit card which will be applied to your account. Your bank may impose charges as well. We reserve the right to no longer accept checks from a patient at any time.

I have read, understood, and agree to Fall Creek Internal Medicine Financial Policy Agreement. I authorize the release of any information my insurance company may need to process my claim, and I authorize my insurance company to issue payment directly to Fall Creek Internal Medicine, LLP. In the event I have a personal balance owing, I will promptly pay balance to bring account current. Failure on my part to pay my personal financial obligations to Fall Creek Internal Medicine, LLP could result in my account balances being turned over to collections. I agree to pay any accounting service charges assessed by the billing department on balances over 60 days.

_____ _____

Patient Signature (or responsible party for patient) Date

_____

Printed Name

COPY AVAILABLE UPON REQUEST