

# COAST ALLERGY/ASTHMA CENTER

Raymond E. Brady, MD  
Physician & Surgeon

## PATIENT'S RESPONSIBILITY FOR PAYMENT

In order to reduce confusion and misunderstanding between our patients and the medical practice, we have adopted the following financial policy. If you have questions about the policy, please discuss them with our office manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

We will submit charges for medical treatment to your insurance company and, where applicable, to Medicare. However, you are responsible for paying any and all medical expenses incurred at the clinic.

We do not verify in advance your insurance coverage. You should contact your insurance companies directly for any coverage questions you may have. If the insurance company denies payment or will only pay a portion of the medical bill, you are still responsible for payment of the account balance. Likewise, if you have not met your deductible under a given insurance plan, you will be responsible for the amount of the deductible and whatever amounts the insurance company does not pay.

If you participate in an Oregon Health Plan program, you will be responsible for payment of services related to conditions that are not covered by the Plan. We do not accept Washington DSHS plans nor any workmen's compensation injury or illness claims. If you have any pending claims, you agree that payment for any medical care provided by us will be your sole responsibility.

If you are involved in a motor vehicle or liability accident, you are responsible for paying all medical costs, even if there is a pending lawsuit.

## Patient Responsibility (Disclaimer)

I understand that my insurance plan can require a referral from my primary care physician in order to cover the visits to a speciality physician. Dr. Raymond E. Brady is a specialty physician. If Coast Allergy/Asthma Center at this time has not received verification that a referral was generated for services, and if my insurance company denies payment, I agree that I will be financially responsible for any and all charges incurred (including lab and x-ray).

I understand that lab tests and x-ray procedures will be billed separately from those providers.

If I participate in an HMO or PPO that requires co-payment, I must pay the co-payment at the time of appointment.

If I have valid insurance, I understand that a \$75.00 deposit will be requested at the time of my initial visit, unless my insurance requires only a co-pay. If I do not have insurance, I will be required to make a \$250.00 payment that will be applied to the bill. Any resulting credit/overpayment will be refunded to me.

I hereby assign to Coast Allergy/Asthma Center any and all insurance benefits due me to the fullest extent of my financial obligation. I authorize them and Coast Allergy/Asthma Center to release to the insurance company any information acquired in the course of my examination and treatment as is allowed by H.I.P.P.A. regulations.

## Contractual Agreement to Pay Medical Expenses

***I understand that I am personally responsible for all medical expenses incurred at Coast Allergy/Asthma Center for care and treatment. I agree to pay all medical expenses within 90 days of the date those expenses were incurred. I will be charged interest of 1.5% per month on the account balance if not paid by this date.***

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Patient signature (Parent of Guardian if patient is a minor.)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Printed Name