COLUMBIA GORGE
FAMILY MEDICINE

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Hood River, OR 97031

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CGFM Financial Policies

Date: ____________ (mm/dd/yyyy) **Birthdate:** ____________ (mm/dd/yyyy)

Patient Name: ____________________________ (last name, first name, middle initial)

Thank you for choosing Columbia Gorge Family Medicine (CGFM) for your healthcare services.

Please review the policies below carefully and feel free to ask questions should you have them. In order to ensure accurate billing and to prevent fraud, we ask each patient to provide us a copy of a photo ID along with their insurance card. When you receive a new insurance card or change to another health plan, it is your responsibility to inform us with updated policy info and provide us with a copy of the card
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We bill your insurance as a courtesy and must have accurate health plan information. This includes primary and secondary, automobile and workers' compensation insurances. Failure to provide us with accurate and up-to-date information specific to your visit will result in patient responsibility for the balance owed.

It is the patient's responsibility to check with their health plan for eligibility and benefit details including: 1) In-network provider status; 2) Primary Care Provider (PCP) assignment; and 3) potential financial responsibility for services not covered on or after the date of service at CGFM. **By signing below, I accept this responsibility.**

Most office visits require a co-pay which is due at the time of service. If your co-pay is not printed on your card and/or we are unable to view when checking eligibility, a standard co-pay of $25 will apply. A percent co-pay or co-insurance fee will be converted to a set amount per CGFM. A charge of $3.95 will be added for estimated copay/coinsurance.

If you don't have health insurance, have a high deductible plan or your account is in collection status, we require a $75.00 deposit every visit.

For visits during extended hours (Acute Care) we collect $85 at the time of service. We will bill your insurance and if payment is made we will refund any monies owed to you. If you are an established patient we will collect based on your insurance plan's estimated patient responsibility.

Patients without insurance, please inquire about our 30% pay in full discount.

In select cases there are payment plan options. For qualification and minimum payment details, consult with billing staff. We charge a $3.95 per month billing fee on all accounts aged over 30 days.

There is a $30 charge on returned checks. Failure to pay your bill or make arrangements with our billing department could result in dismissal from the practice and your account being assigned to an outside collection agency where you will be responsible for all collection cost and attorney fees incurred.

Missing your appointment without calling us to cancel or reschedule within 24 hours will result in a $25 fee. After three (3) no-shows, your account will go to review for dismissal.

I understand and agree to Columbia Gorge Family Medicine's financial policies as described above.

Signed ____________ (mm/dd/yyyy) **by** ________________________________ Signature of patient

Signed ____________ (mm/dd/yyyy) **by** ________________________________ Signature of parent, guardian, or legal representative