Financial and Appointment Policy and Agreement

West Linn Primary Care – Huey Meeker, M.D.

The primary goal of our practice is to provide the finest adult medical care in our community. Since our practice has obligations that must be met, we ask that you agree to abide by our payment policies.

For your convenience, we accept cash, check, Visa, and MasterCard.

Insured Patients

All co-pays and deductibles are due at the time of your office visit.

As a courtesy, we will bill your primary and secondary insurance for you. However, insurance coverage is an agreement between you and your insurance company for payment of medical services. You are responsible for understanding your coverage benefits. It is your responsibility to call your insurance company ***before*** your first appointment with us to verify that Dr. Meeker is an "in-network" provider under your insurance plan, and to verify how much your co-pay or deductible is for a "primary care office visit." It is also your responsibility to assure that we have your most updated insurance information on file.

You are responsible for paying for your co-pay, deductibles, and ANY BALANCE DUE after your insurance has been billed and has paid their part.

Please contact our office *before your appointment* if you need assistance verifying your insurance benefits at 503-636-1133 or info@westlinnprimarycare.com. **Initials**_____

Self-Pay Patients

If you do not have proof of insurance, you will be considered a self-pay patient. **We charge a flat rate of $100.00 per office visit. This entire fee is due at the time of your appointment.** This fee includes office visit to see the physician; blood draw fee (if we draw your blood *in our clinic*); simple lab tests performed *in our clinic*, i.e.…strep test, mono test, pregnancy test; minor procedures performed *in our clinic*, i.e.…sutures, mole removal. This fee does **NOT** include tests performed *outside of our clinic*, such as x-rays, MRI scan, CT scan, ECG's, etc… It does **NOT** include any lab work that needs to be sent to an outside lab for testing. You will receive separate bills in the mail for services that are performed *outside of our clinic* and it is your responsibility to pay these bills. **Initials**_____

Collections/Payments

If you have a delinquent account with our clinic past 60 days, without attempting to contact us and make payments, we will assign your account to a collection agency.

Should you receive a bill from us and find yourself in a financial bind, please call us to discuss setting up a payment plan. If more charges are added to the balance, new payment arrangements will need to be made. We are happy to help and are here to assist you. Please contact our office manager at info@westlinnprimarycare.com to set up a payment plan.

- **Checks:** We will **only** accept checks from existing patients that are in financially good-standing with us. If your check comes back to us as "insufficient funds" you will owe us $35.00 (bank fee charged to us for a bounced check), *in addition* to the amount that the original check was written for. You will be asked to pay by cash or credit card for future visits to our clinic. **Initials**_____

Appointment Cancellation

"No Show" or missed appointment fee is $25.00.

We know circumstances arise preventing you from coming to your appointment. Please call 24 hours in advance to cancel or reschedule appointments. If you miss your appointment *without cancelling in a timely manner and do not attempt to contact us* we will consider this a "no show." **Initials**_____

Our Rights

West Linn Primary Care has the right to dismiss a patient from our practice for outstanding delinquent accounts and/or for ongoing missed appointments. We also have the right to refuse service to patients that are verbally abusive and/or threaten Dr. Meeker and our staff in any way.

Yes, I have read and understand this *Financial and Appointment Policy* for West Linn Primary Care. Signing below indicates that I agree and will abide by this policy.

_____ _____

Signature of Patient or Legal Representative of Patient **Printed Name**

Date _____