SOUTH PORTLAND
SURGICAL
CENTER
6370 SW Borland Rd., Suite 100
Tualatin, Oregon 97062
503.218.1105

# FINANCIAL / BILLING POLICY

## IMPORTANT INFORMATION

***Please read the following information carefully as it applies to your financial responsibility. Thank you in advance for your cooperation.***

*South Portland Surgical Center, LLC (the "Center") is providing this information to explain our financial and billing policy. We appreciate your assistance in reducing the overall cost of your medical care by cooperating with these policies.*

**INSURANCE CLAIMS**

Your medical insurance policy is a contract between you and your insurance carrier and the Center is not a party to that contract. As a result, your coverage and responsibilities are determined by your policy and you are responsible for understanding and following their required procedures. On your behalf, the Center will submit all claims for our services with your primary and secondary insurance providers. It is your responsibility to provide us with sufficient, accurate and up-to-date insurance information. If your insurance company does not submit payment, you are liable for your account balance and we will request immediate payment from you. It is your responsibility to contact your insurance company with any questions and to respond to any inquiries from them in a timely manner regarding your condition or procedure. In some instances, even though the Center files the claim on your behalf, your insurance company may send the Center's payment directly to you. *If you receive a payment directly from the insurance company, you hereby agree to immediately forward the payment to the Center.*

**PRIOR AUTHORIZATIONS AND PRE-CERTIFICATION**

If your medical insurance plan requires you to have a prior authorization or pre-certification to be on file for a procedure, this should be obtained before your scheduled appointment. IF WE DO NOT HAVE THE REQUIRED PRIOR AUTHORIZATION OR PRE-CERTIFICATION, YOU WILL BE FULLY RESPONSIBLE FOR PAYMENT OF SERVICES RENDERED AT THE CENTER. The Center makes every attempt to follow-up with your physicians' office to see that the authorizations are obtained prior to the surgery; however the authorization must be obtained by the performing physician.

**CO-PAYMENTS, DEDUCTIBLES, AND NON-COVERED SERVICES**

All co-payments and deductible amounts not yet met in this calendar year and estimated balance of co-insurance is due on the day of surgery providing the Center's contract with your carrier provides for collection at the time of service. Similarly, if you have no medical insurance, choose not to use your benefits, or request a service that is not covered by your insurance policy, or incur any other amount that may not be covered by insurance, we request that payment for all services be made in full at the time services are rendered.

**PAYMENT RESPONSIBILITY**

After your insurance has been billed, you remain responsible for payment of the entire balance. When a balance remains we will send you a statement, which is due upon receipt. For your convenience we accept payment by Visa and MasterCard, American Express and Discover.

## COLLECTIONS

I understand I am financially responsible for and agree to pay any charges not covered by the insurance payment. If it is necessary to file a formal collection action against me I agree to pay all costs, including reasonable attorney's fees incurred by APS, LTD in the collection of the outstanding debt.

## MINORS

A parent or legal guardian must accompany a minor and consent to treatment, unless otherwise stipulated by law. Parents or legal guardians must comply with the terms of this billing policy. If the parents of a minor are separated/divorced, the Center has the right to require legal documentation determining which parent is financially responsible for paying the child's medical expenses or responsibility for determining the child's medical care needs. The parent or guardian that accompanies the minor to an office visit will be held responsible for payment of services should any dispute over payment arise.

## PLEASE PROVIDE COMPLETE INFORMATION

If your information has changed, you need to notify our business office of the updated information as soon as possible. You are responsible for keeping us informed of any insurance or address changes and failure to do so may result in responsibility for any balance due. The Center will not be responsible for any errors or lack of coverage or payment due as a result of missing or incomplete information.

**THE UNDERSIGNED CERTIFIES THAT HE / SHE HAS READ THE BILLING POLICY AND RECEIVED A COPY OF THE FOREGOING, AND ACCEPTS ALL THE TERMS AND CONDITIONS STATED ABOVE. In the event Patient is a minor, the undersigned guarantees the performance of all covenants of the above Agreement on behalf of the Patient. If the Patient has any questions about this billing policy he / she should contact the Business Manager at 503-218-1105.**

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**Patient or Authorized Representative** **Date**

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**If not patient, relationship to patient**

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**Print Name**