

Northwest Family Medicine

Agreements & Policies

Authorization and Agreements for Treatment, Emergency Care, or Out Patient Services at NWFM

1. **Consent to Treatment:** I hereby grant consent for treatment or services to be provided by the physicians and employees of Northwest Family Medicine, and I also certify that no guarantee or assurance has been made as to the results which may be obtained.
2. **Consent to Treat Minor:** I am the parent or legal guardian. I hereby consent to treatment or to services to be provided by the physicians and employees of Northwest Family Medicine.
3. **Release of Medical Information:** I hereby authorize Northwest Family Medicine to release any medical information or charges in connection with these services to, but not limited to, an insurance carrier, workmen's compensation carrier, medical service companies, Health & Welfare Funds or the patient's or responsible parties employer.
4. **Insurance Assignment:** I hereby assign medical benefits of any type whatsoever arising out of any policy of insurance insuring the patient or any party liable for the patient's care to Northwest Family Medicine for application to the patient's bill.
5. **Financial Agreement:** For and in consideration of the care and treatment provided to the patient, I agree to pay Northwest Family Medicine all charges for services rendered to or in behalf of the patient.
6. **NextGen EMR:** Limited information is shared between NextGen providers, including medications, diagnosis and drug allergies. To allow for continued sharing which may include mental health medications and diagnosis; **INITIAL** _____

Office Policies and Practices

1. We remind you that your medical insurance is a contract between you and your insurance company and does not affect your responsibility to our office for prompt payment.
2. We may furnish information to insurance companies regarding services rendered.
3. As a service to our patients, most insurance companies will be billed.
4. Minimum payment on account balances less than \$200.00 will be \$20.00
5. Minimum payment on account balances over \$200.00 will be 10% of the balance.
6. There will be a \$3.00 re-billing fee assessed if minimum payment is not made within the billing cycle.
6. Accounts past due for 60 days will be forwarded to a collection agency.
7. A \$15.00 charge will be assessed for any NSF check received as a payment on accounts.
8. A \$25.00 charge will be billed directly to patient for missed appointments. A \$50.00 charge will be billed directly to the patient for missed Wellness Exam/Physical appointments. These fees are not paid by insurance and are the direct responsibility of the patient.

By signing below, I acknowledge that I fully understand and agree to the policies and practices of this office. I also agree that all the information provided is true to the best of my knowledge. I also hereby authorize the payment of insurance benefits for professional services rendered to NWFM Physicians, 605 Welch Street, Silverton, OR 97381.

Print Patients Name

Patients Date of Birth

Signature of Patient/Parent/Guardian

Date