NEHALEM BAY
HEALTH CENTER & PHARMACY
COMPASSIONATE COMMUNITY CARE

Received By: _____
Entered By: _____

885 Nehalem Blvd | PO Box 176 | Wheeler, OR 97147 | 1-800-368-5182 | Fax: 1-844-712-3001 | Nehalembayhealth.org

PATIENT ACCEPTANCE OF FINANCIAL RESPONSIBILITY

PLEASE READ CAREFULLY

Thank you for choosing Nehalem Bay Health Center & Pharmacy as your healthcare provider. The medical services you seek may have a financial responsibility on your part for the costs of health care services that are not covered by your insurance company or health plan. This responsibility means you must pay in full for the services you receive that are not paid by your insurance company or health plan, unless payment is waived or reduced because of financial hardship. If you have a financial hardship, please let us know so we can assess your need according to our policies.

To help you understand your financial responsibility, we ask that you read and sign this form. If you have any questions regarding your financial responsibility, please ask us and we will be happy to answer all your questions. If someone else (parent, spouse, domestic partner, etc.) is financially responsible for your expenses or carries your insurance, please share this form with them, as it explains our practices regarding insurance billing, copayments, and patient billing.

By signing below and/or by receiving medical services from Nehalem Bay Health Center & Pharmacy, you agree:

1. You acknowledge and agree to the terms of this PATIENT ACCEPTANCE OF FINANCIAL RESPONSIBILITY form. Nehalem Bay Health Center & Pharmacy is operated according to financial policies that apply to all patients and clients. You may request a copy of the current policies from the Business Office Staff and/or front desk receptionist. Please understand, however, that these policies may be changed from time to time by Nehalem Bay Health Center & Pharmacy, without notice.

2. You are ultimately responsible for all payment obligations associated with your treatment or care, and you guarantee payment for these services. You are responsible for deductibles, co-payments, co-insurance, non-covered services, or any other patient responsibility indicated by your insurance carrier or our policies, that are not otherwise covered by supplemental insurance.

3. You are responsible for knowing your insurance policy or health plan. For example, you will be responsible for all charges if any of the following apply:

(i) your health plan or insurance policy requires prior authorization or referral by a Primary Care Physician (PCP) before receiving services at Nehalem Bay Health Center & Pharmacy, and you have not obtained such an authorization or referral;

(ii) you receive services in excess of such authorization or referral;

(iii) your health plan or insurance policy determines that the services you received at Nehalem Bay Health Center & Pharmacy are not medically necessary and/or not covered by your health plan or insurance policy;

(iv) your health plan or insurance policy coverage has lapsed or expired at the time you receive services at Nehalem Bay Health Center & Pharmacy; or

(v) you have chosen not to use your health plan or insurance policy coverage. If you are not familiar with your plan or insurance coverage, we recommend you contact your carrier or plan provider directly. For example, some health plans or insurance policies may not cover acupuncture, naturopathic medicine, or certain counseling services. This would mean that you are responsible for the complete cost if you receive services like these and the services aren't covered by your health plan or insurance policy.

4. You will be required to follow all registration procedures, which may include updating or verifying personal information, presenting verification of current insurance, providing signatures, and paying any co-pays or other patient responsibility amount at each visit. Your insurance card or other insurance verification must be on file for your insurance to be billed. If we do not have your card on file or are unable to verify your eligibility for benefits, you will be considered a self-pay patient. As a self-pay patient, you will be required to pay your fee in full at the time of service. If the insurance card or other necessary information is furnished after the visit, we may file a claim with your insurance, and, if paid in full by your insurance, you will be reimbursed. If, during your visit, you are not prepared to pay your co-pay and/or any other treatment fees for which you may be responsible, your appointment may be re-scheduled by Nehalem Bay Health Center & Pharmacy.

By signing this form, I agree that I have read and understand this Patient Acceptance of Financial Responsibility, and I agree that I will be personally responsible for the payment in FULL unless I quality for financial assistance of the charges for services not covered by a health insurance or health plan.

_____ _____

Patient name Patient/Guardian signature

_____ _____

Witness Date