MT SCOTT EAR, NOSE AND THROAT, & SLEEP MEDICINE
9280 SE Sunnybrook Blvd. Ste 300, Clackamas OR. 97015
P: 503.233.5548 F: 866.663.1070

Patient Policies for Mt Scott ENT & Sleep Medicine

Insurance: We are contracted with most insurance plans. If you are not covered by a plan that we do business with, payment in full is expected at each visit. It is the responsibility of the patient to know their insurance benefits, deductibles, and co-insurance requirements. Please contact the insurance company with any questions regarding coverage.

Co-Payments and Deductibles: All co-payments and deductibles must be paid at the time of service.

Non-Covered Services: Please be aware that some – and perhaps all – of the services you receive may not be covered or not considered reasonable or customary by Medicare and other insurance carriers. These services must be paid for at the time of your visit. If prior authorization is needed we will assist you in any reasonable manner to obtain coverage.

Proof of Insurance/Insurance Coverage Changes: We must have a copy of your current insurance card/s in order to bill your insurance. We ask that you bring your card with you to each visit. If you fail to provide us with current insurance information, you will be responsible for the balance of your claim at the time of service. If your insurance changes, please let us know prior to your next visit. This allows us to make any appropriate changes to help you achieve your maximum insurance benefit.

Insurance Claim Submission: We are happy to submit claims to both your primary and/or secondary insurance, provided we have the necessary billing information on file. Please be advised, if your insurance does not pay, the balance will be billed to you.

Cash Patients: Patients who choose to pay cash will receive a 40% discount if paid in full at time of service. Acceptable forms of payment are cash, personal check or credit card. This discount does not apply to hearing aids, equipment, accessories, or Cosmetic procedures.

Returned Checks: If your check is returned for insufficient funds, there will be a $25 fee added to your account, in addition to the amount the check was for. These fees must be paid in full prior to any future appointments.

Nonpayment: If your account is over 90 days past due it will be referred to a collection agency. By signing this agreement you are authorizing The Clinic to release all information needed to secure payment.

Late Appointment/No Show Policy: If you arrive 10 minutes late or more to your appointment you may be asked to reschedule, unless the physician's schedule can still accommodate you. Priority will be given to the patients who arrive on time, you will be worked in between them, and there may be additional wait time. You may choose to reschedule for another day/time. If you are a new patient and you arrive **at** the scheduled appointment time but without enough to complete the new patient paperwork prior to your scheduled appointment time, you may also be asked to reschedule.
We reserve the right to charge $50 for missed office visits, missed in office surgeries, and missed Home Sleep Test pick-ups. These charges will be billed directly to you and must be paid in full prior to additional visits. Excessive missed appointments may result in discharge from the practice.

Paperwork and Letters: Please, be advised that extensive paperwork and letters written on your behalf may be subject to a $25 fee.

Prescription Refills: Please, call your pharmacy for all prescription refills. They will contact our office for necessary information. Please, allow 24-48 hours for all requests. Please, note that an additional 48 hours is necessary if prior authorization is required by your insurance company. Please, be sure that all refill requests are received by 4:30pm on Thursdays; the on-call physician will not refill prescriptions over the weekend.

Motor Vehicle Accidents: We do not bill auto insurance. You will be required to pay all charges at the time of service. We can provide you with a billing form that you can provide to your insurance company.

Worker's Compensation: We do not see patients for Worker's Compensation visits.

On-call Physicians: Our practice is covered 24 hours a day 7 days a week. After hours calls should be made only in the event of an urgent issue. Routine prescription refills, appointment scheduling and billing questions are not issues that the on-call physician can assist you with. Please call during regular business hours with all non-urgent inquiries.

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Acknowledgment of Patient Policies for Mt Scott ENT & Sleep Medicine

In Office Procedures: Please be advised that during your visit the doctor may need to perform an in-office procedure. This can include the use of an endoscope to look at your nasal passages or throat. These procedures are medically necessary for the doctor to accurately diagnose your condition. Employing the use of these and procedures is the standard of care for providing complete and comprehensive otolaryngology services in an office setting.

Insurance companies will consider all of these procedures "surgical". We do not have control over how endoscopies are interpreted by insurance companies. Diagnostic endoscopies are always considered "surgical" despite the fact that no surgical instruments are used. This serves as advance notice so that you are not surprised when you receive an explanation of benefits from your insurance that states a "surgical service" was provided. Also, surgical services may be reimbursed or paid at a different rate than an office visit and may be applied towards your deductible and/or co-insurance.

Please initial and date here that you understand the in-office procedure notification: **Initial: __________ Date: ____________**

Thank you for taking the time to review our policies. By signing below you are acknowledging that you have read, understand, and agree to abide by the policies set forth by Mt. Scott ENT & Sleep Medicine. Should you have any questions regarding these, please let us know.

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Signature of Patient or Responsible Party Date

Acknowledgment of Receipt of Privacy Policy

I acknowledge that I have been offered and/or provided a copy of, have read and understand the Notice of Privacy Policy for *Eastmoreland Ear, Nose, and Throat Clinic, LLP; Mt Scott Ear, Nose and Throat and Sleep Medicine; Dr. James Chan; Aleen Lee, MD, Valerie Ing, DO and Joshua Pluim, AuD.* (the "Covered Entities") containing a complete description of my rights, and the permitted uses and disclosures under HIPPA.

While the Covered Entities have reserved the right to change the terms of the Notice of Privacy Policy; copies of the Policy as amended are available at the office or by sending a written request with return address to: Privacy Officer, Eastmoreland ENT, 9280 SE Sunnybrook Blvd. Suite 300 Clackamas, OR 97015

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Signature of Patient or Patient Representative Date

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Printed Name of Patient or Patient Representative Relationship

Release of Verbal Medical Information

Mt Scott ENT restricts the release of protected health information (PHI) to that permitted by patient confidentiality laws. According to HIPAA regulations, permitted reasons for release of PHI include treatment, payment and healthcare operations, or as otherwise allowed by the ***specific signed authorization*** of the patient or authorized personal representative. The purpose of this Release of Verbal Medical Information form is to provide our patients an opportunity to permit verbal release of PHI in the following two (2) ways: Certain information cannot be released without specific authorization as required by state or federal law. By *initialing* the lines below, you authorize the release of the following protected or sensitive information:

_____ Diagnosis / Treatment Plans _____ Labs / Imaging results / Scheduling

_____ Prescription information _____ Billing / Insurance Claims

*This authorization will expire 2 years from the date of signing. *You have the right to revoke this authorization, in writing, at any time. *I understand that such revocation is not effective to the extent that the clinic has relied on the use or disclosure of the protected health information. *I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by recipient and may no longer be protected by state or federal law.

I hereby authorize medical providers and personnel of Mt. Scott ENT & Sleep Medicine to discuss my protected health information with the following person(s):

____

Name Phone Relationship

____

Name Phone Relationship

___ **I decline.** Please do not discuss my protected health information with anyone other than is allowed by HIPAA regulations.