

Willamette
valley Clinics

SECTION: Financial	NUMBER	
TITLE: Financial Policy	EFFECTIVE DATE	10/1/2011
	REVISION DATES	
PAGE NUMBER:	REVIEW DATES	
REVIEW RESPONSIBILITY: Manager, CBO		

Purpose: To ensure fees and patient out of pocket expenses are collected by WVC, LLC employees when services are rendered.

Non-Insured: Payment is due at the time the service is rendered. Patients are offered a prompt pay discount of 40% for Primary Care and 50% for Specialist services if paid at the time of service.

Patients with balances greater than \$500.00 will be expected to make a minimum payment equal or greater than ¼ of the total amount due. The balance should be paid in full within (4) months from the date of service. Failure to comply will result to further collection activity.

Patients with balances less than \$500.00 will be expected to make minimum payments equal or greater than 1/3 of the total amount due. The balance should be paid in full within (3) months from the date of service. Failure to comply will result to further collection activity.

Insured Patients: Co-payments, deductibles, and/or Co-Insurance are due at the time of service. If patients provide valid insurance information, WVC, LLC will bill insurance on an assigned basis. Charges not covered by the patient's insurance will be billed to the patient as outlined on the Insurance explanation of benefits.

Cash, Check, and most major credit cards are accepted. A \$25.00 fee will be charged to the patient per occurrence for any funds returned by the financial institution for non-payment.

Delinquent accounts will be referred to CBC Collection Agency for further collection efforts. Accounts are considered delinquent if unpaid after 90 days and referred after 150 days of non-payment. In the event a patient account is referred to the collection agency, the patient will be required to pay the outstanding balance in full prior to receiving further treatment. Delinquent accounts that are referred to the collection agency are subject to dismissal.

Billing inquiries should be directed to the WVC, LLC Clinics Business Office.

Patients are to receive, review and sign the Financial Policy (Addendum 1) prior to receiving services.



Patient Financial Policy

Patient Name: _____ **Account #** _____ **Date** _____

Thank you for choosing Willamette Valley Clinics, a division of Capella Healthcare. We are strongly committed to providing you and your family with the best available medical care.

We are pleased to accept and bill your insurance we contract with, on an assigned basis subject to verification of your coverage. Please understand that your insurance plan is between you and your insurance company; therefore, Willamette Valley Clinics, LLC will not become involved in any disputes you encounter with your coverage or become engaged in litigation with your insurance company. You are fully responsible for any amounts not paid by your insurance.

We accept Cash, Check and most credit cards. You will be charged a \$25.00 fee for any payments returned by your financial institution for non-payment.

Non-Insured Patients: Payment is due at the time of service unless previous payment arrangements are made. We offer a 40% prompt pay discount in our primary care clinics and a 30% prompt pay discount in our specialty care clinics when paid in full at the time of service.

Insured Patients: All out of pocket expenses including co-payments, deductibles and/or co-insurance are due at the time of service. It is your responsibility to provide us with your insurance information prior to receiving services. Verification of benefits is not a guarantee of payment and you will be responsible for any services considered non-covered by your insurance. If for any reason your insurance company does not cover services you received within (60) sixty days, the full amount billed will become your responsibility to pay immediately.

Worker's Compensation: If you were injured at work and want us to bill your employer's workers compensation carrier, we may need to get authorization from the carrier in order to treat you. If authorization is not obtained, we may not be able to provide services to you.

Motor Vehicle Accidents: If you were injured as a result of an motor vehicle accident and want us to bill motor vehicle insurance, we require a deposit of 1/2 of our fees prior to providing services. We will bill your motor vehicle insurance on an assigned basis. In the event we receive full payment from your auto insurance, we will refund the amount you overpaid. You will be responsible for any balances not covered by your auto insurance.

I have read, understand and agree to the above Financial Policy. I understand that charges not covered by my insurance company, as well as applicable out of pocket expenses, are my responsibility.

Date

Patient or Guarantor Signature

Printed Name