NORTHWEST SURGICAL SPECIALISTS, LLP

MISSION STATEMENT

Northwest Surgical Specialists is dedicated to providing a full spectrum of surgical care with respect for our patients and community.

FINANCIAL POLICY

Thank you for choosing us as your health care provider. We require you read and sign the policy prior to any treatment.

Please understand that you may be responsible for the payment of services rendered, including patient and patient representative communications, if the services are not covered by your insurance. It will be your responsibility to verify with your insurance carrier the plan participation status of your provider prior to a service being rendered.

We participate with Medicare which means we accept Medicare assignment and bill you for the 20% coinsurance and any non-covered service.

The adult accompanying a minor and the parents (or guardians of the minor) are financially responsible for the minor's treatment charges.

Co-payments are due at the time of your appointment. Co-payments, deductibles, co-insurance, non-covered services (including pre-existing conditions), and services denied due to lack of referral are your responsibility.

We accept cash, check and VISA, Mastercard, or Discover as acceptable forms of payment.

If your insurance does not pay your account in full within 45 days of service, you will be responsible for the balance. If you cannot meet this obligation, you agree to pay 25% of the total balance each month unless other payment arrangements have been made with our Business Office. Payments are due within 10 days of the statement date.

If you do not abide by this payment agreement and your balance becomes delinquent, you understand that your account may be forwarded to a collection agency. You agree to pay any collection cost, including attorney fees.

If you have any question regarding this agreement, please call our Business Office at 868-9307.

ASSIGNMENT OF INSURANCE BENEFITS:
I assign medical benefits paid by my insurance carrier(s) to Northwest Surgical Specialists, LLP, for application to my bill. I acknowledge that I will be billed for charges not covered under my insurance policy.

RELEASE OF INFORMATION:
I hereby authorize Northwest Surgical Specialists, LLP to furnish the insurance company(s), employer, other payor(s) or their representatives, of either myself or the subscriber, or to the referring physician, any and all information required to process my claim.

Patient Name_____

Signature of Patient/Responsible Party/Guardian_____
Date_____

ACKNOWLEDGMENT of HIPAA POLICY (REV11/07/2019)

I understand that Northwest Surgical Specialists, LLP(referred to below as "This Practice") will use and disclose **health information** about me.

I understand that my **health information** may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that This Practice may **use and disclose** my health information in order to:

- make decisions about and plan for my care and treatment
- refer to, consult with, coordinate among, and manage along with other health care providers and facilities for my care and treatment;
- determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care. I understand that if I pay out of pocket in full (full payment must be received prior to service being performed) for a specific item or service, I have the right to ask that my Protected Health Information with respect to that item or service not be disclosed to a health plan.
- perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.
- To promote quality of care, we use electronic community health records that share health information among many providers. These computer systems are used by many providers including those not affiliated with us. These electronic community health records lets us and other providers look at and/or add information about you, your health, the care you receive, and other important facts. Not all your information is kept on the community health records. Not every provider that treats you looks at or adds information in the community health records. We cannot remove information once it is placed in the community health records.

I also understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written description is known as a **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of This Practice, and my rights regarding my health information.

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact our Compliance Officer at (541) 868-9303. You will not be penalized for filing a complaint.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of This Practice's Notice of Privacy Practices in effect will be posted in waiting/reception area and on the company website.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that This Practice is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I have been offered a copy of the Notice of Privacy Practices

Requires Patient Signature or Patient Representative (Identify your signature as "representative") below:

By: _____ **Date:** _____