Canby HealthCare Clinic, LLC
703 SE 1st Ave.
Canby, OR 97013
Phone: 503.266.7686 Fax: 503.266.7382

Patient Name (Last, First, Middle Int.): _____

Date of birth: _____ M/ F_____ SSN: _____

Address: _____ City / State / Zip: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Ethnicity: _____ Race: _____ Language Preference: _____

Preferred Pharmacy (Name and City): _____

Employer / School Name: _____

Are you or any of your family members a migrant worker/seasonal worker? _____YES _____NO

Emergency contact: _____ Relationship: _____ Phone: _____

Insurance: _____ ID #: _____ Group #: _____

Statement of Financial Responsibility

I understand that I am financially responsible to pay Canby Healthcare Clinic, LLC for charges incurred, whether covered or not by health insurance. I further agree that, in the event of non-payment, to bear the cost of collection, court costs, and / or responsible for legal fees, should this be required. A finance charge of 1.5% will be added to accounts 30 days and over. The APR is 18%. I HEREBY AUTHORIZE AND DIRECT PAYMENT OF ALL MEDICAL BENEFITS DIRECTLY TO CANBY HEALTH CLINIC, LLC.

Billing and Payment Policy

UNLESS INSURANCE COVERAGE HAS BEEN VERIFIED OR OTHER ARRANGEMENTS HAVE BEEN MADE, FULL PAYMENT IS EXPECTED AT THE TIME OF APPOINTMENT. If we cannot verify your insurance we expect payment. You will be refunded any amount due to you when the insurance payment is received. The full balance of your account is due upon receipt of the monthly statement and is past due 30 days from the statement date unless prior payment arrangements have been made with this office. If your situation prevents compliance with this policy, please inquire today to discuss your bill with your business manager.

Insurance

As a courtesy, we will bill your insurance carrier (s) for you. However after 60 days from the date of service, you are responsible for the balance. Please remember insurance is a contract between you and your insurance company and is not a substitute for payment. We cannot be responsible for collecting from your insurance company or negotiating a settlement on a disputed claim. We look to you directly for payment.

I have carefully read and fully understand the above statements.

_____

Patient Name (Please Print)

_____ _____

Signature of Responsible Party (Permission of Medical Treatment) **Date**