SALEM PULMONARY ASSOCIATES, PC AND SLEEP CENTER
801 MISSION ST SE
SALEM, OR 97302-6222
503-588-3945 503-588-0256 FAX

Salem Pulmonary Associates, P.C. and Sleep Centers goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our office policy, allows for a good flow of communication and enables us to achieve our goal. Please read this carefully and if you have any questions please do not hesitate to ask a member of our staff.

1. Upon arrival, please present your current insurance card(s) at every visit. Please inform us of any changes in your personal information.
2. It is your responsibility to understand your insurance plan and if a written referral or authorization is required to see a specialist, if preauthorization is required prior to a procedure and what services are covered. Please be aware that if you choose to be seen before you have received a valid authorization your insurance may not pay for the visit. The Business Office cannot guarantee payment for services or coverage of services from your health plan. Patients are ultimately responsible for understanding their coverage limitation and benefits.
3. According to your insurance plan, you are responsible for any and all co-payments, deductible and co-insurances at time of service. Co-payments are the amount your policy requires us to collect with each visit. Please be prepared to pay at the time of your visit. The co-insurance is the percentage of the bill that is your responsibility according to the contract with your insurance company. The deductible is the total amount your policy requires you to pay before they pay a claim on your behalf. We will be collecting a portion or all of your owing co-insurance or deductible at the time of your office visit. We accept cash, check, Visa, Mastercard and American Express.
4. Patients without insurance or seeing a provider out of network will be required to make a deposit at the time of the visit at the following rates: New patient office visit- $100 deposit, Established patient office visit-$100 deposit, Sleep Study procedures-$100 deposit.
5. Patient balances are billed immediately upon receipt of your insurance plans explanation of benefits. Your remittance is due 10 business days from receipt of your bill.
6. If previous arrangements have not been made with our finance office, any account balance over 90 days will be turned over to a collection agency.
7. A $25 fee will be assessed for all appointments cancelled without a 24 hr notice.
8. A $35 fee will be assesses for not showing up for your scheduled appointments.
9. **Patients who accumulate a total of 3 No Show/Same Day cancellations within a 12 month period, will automatically be TERMINATED from SPA as a patient. Exceptions will be made dependent on circumstances.**
10. **If you have not been seen in over one (1) year, Salem Pulmonary Associates, P.C. and Sleep Center WILL NOT REFILL ANY PRESCRIPTIONS UNTIL YOU ARE SEEN.**

I acknowledge that I am financially responsible for all charges whether or not they are covered by my insurance. I understand and agree that health insurance policies are an arrangement between an insurance carrier and myself and that my doctor and/or his staff are not the administrators of the policy. I authorize payment of my medical benefits to Salem Pulmonary Associates, P.C. and Sleep Center and my doctor for medical services rendered. A photocopy of the signature is as valid as the original.
If it becomes necessary to effect collections for any amount owed on this or subsequent visits, the undersigned agrees to pay for all the costs and expenses, including reasonable attorney fees. I hereby authorize the doctor to release information necessary to secure payment. Any check returned to Salem Pulmonary Associates, P.C. and Sleep Center due to non-sufficient funds will be charged a fee of $25.00.
I have read and understand the above Office Financial Policy and agree to comply and accept the responsibility for any payment that becomes due as outlined above.

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Patient Name (Please Print) Date

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Patient, Parent or Guardian Signature