

Central Oregon Sleep Disorders Center  
147 SW Shevlin-Hixon, #101 Bend, OR 97702  
Phone: 541-306-4882 Fax: 541-306-4904

**FINANCIAL POLICY FOR THE OFFICE**

In the interest of good health care practice, it is desirable to establish a credit policy to avoid misunderstandings. Our primary responsibility is to help our patients experience good health and we wish to spend our time and energy toward that end.

- All accounts are due and payable at the time of your visit, unless satisfactory arrangements have been made with our Accounts Manager.
- On accounts that have established arrangements, the payment is due upon receipt of the monthly statement. Any balance outstanding more than 60 days will bear interest at 18% per annum, or 1.5% per month.
- We will gladly bill your insurance company, as a courtesy, when you provide any necessary forms and us with current information. Even though you may have an insurance claim pending, you will receive a monthly statement for the outstanding balance on your account. We cannot accept responsibility for collecting an insurance claim after 60 days or for negotiating a disputed claim. Insurance reimbursement is a contract between you, your employer, and the insurance carrier. YOU are responsible for payment of your account.
- There will be a charge (\$25 minimum) for any broken appointment or for appointments not cancelled or rescheduled with a 24-HOUR NOTICE. The length of time scheduled for you determines the amount of the charge. We will not reschedule any patient after two appointments have been missed. Our time must be used as efficiently as possible to best serve our patients, keep our expenses at a minimum and our fees within reasonable limits.

I have read this credit policy and understand that regardless of any insurance coverage I may have, I am responsible for payment of my account. I understand that delinquent accounts will be assigned to a credit reporting collection service. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. I give Central Oregon Sleep Disorders my permission to bill and collect any benefits due from my insurance company for charges incurred by me.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Name: \_\_\_\_\_