



- Clackamas Pediatric Clinic, 9290 SE Sunnybrook Blvd., #200, Clackamas, Oregon 97015 (503) 659-1694
- Oregon Pediatrics - NE Portland, PC, 5050 NE Hoyt St., #523, Portland, OR 97213 (503) 233-5393
- Oregon Pediatrics - NE Portland, PC/Gateway, 171 NE 102nd Ave., Portland, OR 97220 (503) 542-4494
- Oregon Pediatrics - Meridian Park, LLC, 19260 SW 65th Ave., #275, Tualatin, OR 97062 (503) 691-2519

So we may properly contact you regarding medical care and correctly bill your insurance, please supply all information below.

P A T I E N T	Last Name:		First Name:		MI:	Suffix:	Preferred/Nick Name:		
	Physical Address:				PO Box (if applicable):		<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth:	
	City:			State:		Zip + 4:		Social Security #:	
	Primary Contact Phone:		<input type="checkbox"/> Home <input type="checkbox"/> Mom Cell <input type="checkbox"/> Dad Cell	<input type="checkbox"/> Other: <input type="checkbox"/> Mom Work <input type="checkbox"/> Dad Work	Other Phone:		<input type="checkbox"/> Mom Cell <input type="checkbox"/> Dad Cell <input type="checkbox"/> Other:	<input type="checkbox"/> Mom Work <input type="checkbox"/> Dad Work	
	Secondary Phone:		<input type="checkbox"/> Home <input type="checkbox"/> Mom Cell <input type="checkbox"/> Dad Cell	<input type="checkbox"/> Other: <input type="checkbox"/> Mom Work <input type="checkbox"/> Dad Work	Other Phone:		<input type="checkbox"/> Mom Cell <input type="checkbox"/> Dad Cell <input type="checkbox"/> Other:	<input type="checkbox"/> Mom Work <input type="checkbox"/> Dad Work	
	Email:				Preferred Physician:		School or Employer Name:		

P A R E N T / G U A R D I A N	Circle/complete as applicable: Parent Step-Parent Foster Parent Grandparent Aunt Uncle Other:								
	Last Name:		First Name:		MI:	Suffix:	Preferred/Nick Name:		
	Physical Address:				PO Box (if applicable):		<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth:	
	City:			State:		Zip + 4:		Social Security #:	
	Primary Phone (if different than above):		<input type="checkbox"/> Home <input type="checkbox"/> Cell	<input type="checkbox"/> Work <input type="checkbox"/> Other:	Marital Status:		Drivers License/State ID #:		
	Secondary Phone (if different than above):		<input type="checkbox"/> Home <input type="checkbox"/> Cell	<input type="checkbox"/> Work <input type="checkbox"/> Other:	Email:				
	Employer:			Occupation:			Work Phone (if not otherwise listed):		

P A R E N T / G U A R D I A N	Circle/complete as applicable: Parent Step-Parent Foster Parent Grandparent Aunt Uncle Other:								
	Last Name:		First Name:		MI:	Suffix:	Preferred/Nick Name:		
	Physical Address:				PO Box (if applicable):		<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth:	
	City:			State:		Zip + 4:		Social Security #:	
	Primary Phone (if different than above):		<input type="checkbox"/> Home <input type="checkbox"/> Cell	<input type="checkbox"/> Work <input type="checkbox"/> Other:	Marital Status:		Drivers License/State ID #:		
	Secondary Phone (if different than above):		<input type="checkbox"/> Home <input type="checkbox"/> Cell	<input type="checkbox"/> Work <input type="checkbox"/> Other:	Email:				
	Employer:			Occupation:			Work Phone (if not otherwise listed):		

P R I M A R Y	Insurance Name:		Identification #:			Group #:		
	Address:		City	State:	Zip:	Effective Date:		
	Subscriber Name (Mother, Father...):		Subscriber DOB:		Subscriber SS#:		Copay Amount:	

S E C O N D A R Y	Insurance Name:		Identification #:			Group #:		
	Address:		City	State:	Zip:	Effective Date:		
	Subscriber Name (Mother, Father...):		Subscriber DOB:		Subscriber SS#:		Copay Amount:	

Contact	Emergency Contact:			Address:		
	Primary Phone:	Type:	Secondary Phone:	Type:	Relationship to child:	
Siblings	List names of siblings in same household:					
	DOB of each sibling:					

**Thank you for choosing Clackamas Pediatric Clinic and Oregon Pediatrics as your health care provider. Our goal is to provide the highest quality medical services to our patients at a reasonable cost.**

Please note the following payment terms and feel free to speak to a bookkeeping representative if you have any questions or concerns.

- \* If you have insurance please be prepared to **present your insurance card at each visit**. We are happy to submit a bill to all major carriers as well as most secondary carriers when all necessary information to do so has been provided to us.
- \* Please note that your insurance coverage and benefit package is an arrangement between you and your insurance carrier. You are responsible to be aware of your benefits and to contact your carrier directly when issues arise. This includes timely payment of claims, denials, rebilling, contracted providers and other such issues. Many insurance plans have limitations on benefits, especially for preventative care (well child care &/or vaccinations). Please contact your insurance company directly to discuss your specific benefits and/or limitations. We are happy to assist whenever possible regarding general insurance benefit questions. We can not quote nor do we guarantee insurance benefits. Regardless of insurance, all services provided are the financial responsibility of the patient or the parent(s)/guardian(s) of patients who are minors.
- \* Uninsured patients are expected to pay for services in full at the time of service unless other prior arrangements have been made.
- \* As a courtesy we will bill third party payors (such as auto insurances relating to motor vehicle accidents) when provided with complete insurance information at time of service. Balances for third party claims are subject to the same payment terms as other services received at CPC/OP.
- \* We offer a "Prompt Pay" discount on most care and treatment when paid in full at the time of service.
- \* Payment for services rendered are due within 30 days of receiving service. We accept cash, credit card & bank debit card. In many cases we can also accept personal checks and money orders. If you are unable to pay in full within 30 days please contact our office to see if you qualify for a payment plan. If approved, regular monthly payments must be made until paid in full.
- \* Accounts may be assigned to an outside collection agency and reported to the credit bureaus when the personal balance is over 120 days old and/or payment plan payments are missed. Patients whose account has been assigned to outside collections are responsible for all agency and/or legal fees incurred. Thereafter future services at CPC/OP are on a cash basis with no extension of credit and may also be subject to dismissal.

Additional Charges:

- 1.5% monthly finance charge (18% APR) added to accounts with personal balance over 90 days old, *including* those for which a payment arrangement has been established. This policy is in effect for services 11-4-2008 & after.
- \$15 - Copay billing. Added to account if copay not paid at time of service. Non-urgent care may be subject to rescheduling when copay is not paid.
- \$25 - Returned check. Added to accounts for which check payment is not honored by the bank.
- \$50 - No Show. Added to account when the patient does not keep a scheduled appointment and doesn't cancel prior to appointment time.
- \$50 - Collection. Added to accounts assigned to an outside collection agency.

Your signature below constitutes your authorization for treatment; acceptance of the payment terms; authorization for Clackamas Pediatrics and/or Oregon Pediatrics to bill the insurance using information on file at the time of service; authorization to release medical data relating to a claim; and authorization to assign benefits directly to Clackamas Pediatric Clinic and/or Oregon Pediatrics.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Relationship to patient

\_\_\_\_\_  
Date