



**Patient Consent for Injury Care
& Financial Policy Agreement**

Patient Name:
Employer:

DOB:
Contact:

Consent for Treatment & Release of Information

I consent to and authorize the examining physician and any assistants or associates to conduct physical exams and perform such tests and treatment as the examining physician deems necessary or appropriate. I also authorize personnel of the clinic to provide routine services requested by the Provider. Should treatment be performed, the Provider will inform me as to the nature of the procedure, the alternatives to treatment and the risks that are involved, I will be given an opportunity to ask questions and have my questions answered. Should special procedures be indicated, I understand that the examining physician will discuss this with me and an additional consent(s) by me will be requested. I understand that this consent to treatment is effective for the duration of my treatment for this injury unless revoked in writing by me.

I authorize the Physician and Clinic to disclose information regarding this injury to my employer and insurance carrier for the duration of my treatment unless this release is revoked in writing by me. I hereby release the Physician and Clinic from any liability from such disclosure.

Financial Policy & Patient Participation Agreement

We are committed to providing you with the best possible care. Our fees reflect our professional commitment to excellence and are in accordance with the State of Oregon’s maximum allowable fee schedule. We are happy to bill your Workers’ Compensation carrier on your behalf and we will also bill your private Health Insurance in the unfortunate event that your worker compensation claim may be denied. In order to achieve these goals we need your assistance and your understanding of our payment policy as well as your participation in your care.

- You will need to provide our clinic with your social security number and health insurance card. The social security number is used to identify your claim. Without the social security number your claim may be denied by the workers’ compensation carrier. Your health insurance information is to be used in the event your worker compensation claim is denied.
- Primary insurance will be gladly billed by Cascade Occupational Medicine as a courtesy; it is the responsibility of the patient to ensure that the clinic has their correct insurance information and to inform the clinic if there are any changes with their insurance provider. The patient will be responsible for any deductible or co-pays applied by their health care coverage. Your health care benefit is a contract between you, your employer and the insurance company; we are not a party to that contract.
- There will be a \$30 minimum charge on all returned checks; payment will then be required in the form of cash, cashier check or money order.

I have read this financial policy and understand the terms for payment. I understand that in the event of a denial by the worker compensation carrier that after the appeal process is exhausted I am responsible for the charges incurred; I understand that my health insurance will be billed as a courtesy and that I am responsible for the unpaid balance. I understand that any delinquent accounts may be assigned to a collection service and that I will be charged for expenses, including any reasonable attorney fees.

Important Information Regarding your Participation in your care:

Healing requires a partnership between you and your Provider. It is expected that you will participate in the healing process. Please be advised that if you do not show up for or cancel your scheduled appointments, we are obligated to inform your Employer and your Worker’s Compensation carrier. No show or cancelled appointments may negatively affect the status and compensability of your claim. It is Cascade Occupational Medicine policy that after two (2) missed appointments we will discontinue care of your injury.

I have read the above Cascade Occupational Medicine policies regarding: consent to care, the release of my personal health information, financial policy and my responsibilities regarding my care and I agree to the terms outlined above.

Patient Signature

Date

COMPI Witness

Date

Optional: Release of Information

I authorize the staff of Cascade Occupational Medicine to leave a message at the phone number I have provided them of :

I authorize the staff of Cascade Occupational Medicine to disclose information regarding my care (including appointment dates, times or medical information to: Spouse (name): Other (name/relationship):

This release is for the duration of my care for this injury or until I revoke this release in writing.

Patient Signature

Date