

ALLERGY, ASTHMA & DERMATOLOGY ASSOCIATES, PC
Physicians & Surgeons

C. Joe Anderson, MD
John A. Kazmierowski, MD
L. René Anderson-Cowell, MD
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Clackamas
9290 SE Sunnybrook Blvd
Clackamas, OR 97015
(503) 653-2123

Downtown
233 NW 16th Avenue
Portland, OR 97209
(503) 223-6480 / (360) 693-1813

Fishers Landing
417 SE 164th Avenue - Suite 300
Vancouver, WA 98684
(360) 254-6844 / (503) 285-4486

Gresham/Troutdale
1620 SW 257th Drive
Troutdale, OR 97060
(503) 667-9000

Hillsboro
705 SE Baseline Street
Hillsboro, OR 97123
(503) 648-1494

Providence
5050 NE Hoyt Street - Suite 223
Portland, OR 97213
(503) 232-3603

Salmon Creek/Rockwell
2415 NE 134th Street - Suite 107
Vancouver, WA 98686
(360) 576-3340 / (503) 294-6150

St. Vincent / Peterkort
9701 SW Barnes Road - #130
Portland, OR 97225
(503) 297-4779

Wilsonville
8642 SW Main Street - Suite 100
Wilsonville, OR 97070
(503) 582-8995

PATIENTS RESPONSIBILITY FOR PAYMENT

In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following financial policy. If you have questions about the policy, please discuss them with our office manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

Allergy, Asthma & Dermatology PC will submit charges for medical treatment to the patient's insurance company and where applicable, to Medicare. However, the patient is primarily responsible for paying any and all medical expenses incurred at the clinic.

Allergy, Asthma & Dermatology PC does not verify in advance the patients insurance. Patients should contact their insurance companies directly for any coverage questions they may have. If the insurance company denies payment or will only pay a portion of the medical bill, the patient is responsible for payment of the account balance. Likewise, if the patient has not met his or her deductible under a given insurance plan, the patient will be responsible for the amount of the deductible and whatever amounts the insurance company does not pay.

If the patient participates in an Oregon Health Plan program, the patient will be responsible for payment of services related to conditions that are not covered by the Plan. If the patient participates in Washington DSHS, the patient will be responsible for all services. Allergy, Asthma & Dermatology PC does not accept Washington DSHS.

Allergy, Asthma & Dermatology PC does not treat worker's compensation injuries or illnesses.

If the patient is involved in a motor vehicle or liability accident, the patient is responsible for paying all medical costs even if there is a pending lawsuit.

Contractual Agreement to Pay Medical Expenses

I understand that I am personally responsible for all medical expenses incurred at Allergy, Asthma & Dermatology PC for medical care and treatment. I agree to pay all medical expenses within 90 days of the date those expenses were incurred.

Patient Responsibility (Disclaimer)

I understand that my insurance plan _____ can require a referral from my Primary Care Physician in order to cover the visits to a Specialty Physician. If Allergy, Asthma & Dermatology PC at this time has not received verification that a referral was obtained for services, and, if my insurance company denies payment, I agree that I will be financially responsible for any and all charges incurred (including lab and x-ray).

If the patient participates in an HMO or PPO that requires co-payment, the patient must pay the co-payment at the time of the appointment.

I have insurance and I understand that a \$75.00 deposit will be requested at the time of my initial visit, unless my insurance requires only a co-pay. If I do not have insurance, I will be required to make a \$250.00 payment which will be applied to the bill. Any resulting credit/overpayment will be refunded to you.

I hereby assign to Allergy, Asthma & Dermatology PC any and all insurance benefits due me to the fullest extent of my financial obligation. I authorize them and the physician to release to the insurance company any information acquired in the course of the patient's examination and treatment.

Patient Signature (Parent or Guardian if patient is a minor)

Date

Patient Printed Name

ALLERGY, ASTHMA & DERMATOLOGY ASSOCIATES, PC
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CJA JAK RAC ACCT. # _____ DATE _____
KSP DGD KMC NEW / UPDATED

PATIENT'S FULL NAME _____ BIRTHDATE: _____ SEX: M / F
STREET ADDRESS _____ SOC SEC # _____
CITY/STATE/ZIP _____ DRIVER'S LIC. # _____
OCCUPATION _____ HOME PHONE _____ CELL PHONE _____
EMPLOYER _____ WORK PHONE _____ EXTENSION _____
EMAIL ADDRESS _____ FAX NUMBER _____

SPOUSE/RESPONSIBLE PARTY _____ RELATIONSHIP _____
STREET ADDRESS _____ SOC SEC# _____
CITY/STATE/ZIP _____ HOME PHONE _____
OCCUPATION _____ CELL PHONE _____
EMPLOYER _____ WORK PHONE _____

NEAREST (LOCAL) RELATIVE/FRIEND (NOT LIVING WITH YOU) TO CALL IF WE CANNOT REACH YOU

NAME _____ RELATIONSHIP _____ HM PHONE _____ WK PHONE _____

IMPORTANT: PLEASE COMPLETE ALL INSURANCE INFORMATION AND PROVIDE A COPY OF INSURANCE CARD

PRIMARY INS CO _____ SECONDARY INS CO _____
INS ADDRESS _____ INS ADDRESS _____
INS PHONE _____ INS PHONE _____
INSURED'S NAME _____ INSURED'S NAME _____
INSURED'S DATE OF BIRTH _____ INSURED'S DATE OF BIRTH _____
ID# _____ ID# _____
GROUP # _____ EFFECTIVE DATE _____ GROUP # _____ EFFECTIVE DATE _____
EMPLOYER _____ EMPLOYER _____

As a service to our patients, we will gladly bill your primary and secondary insurance for you with a copy of your insurance card.

PRIMARY CARE PROVIDER _____ PHONE # _____
STREET ADDRESS _____ CITY/STATE/ZIP _____

Does this provider request a report to be sent to him / her? Y / N

HEALTHCARE SPECIALIST _____ PHONE # _____
STREET ADDRESS _____ CITY/STATE/ZIP _____

Does this provider request a report to be sent to him / her? Y / N

How did you hear about us? Yellow pages Sign Insurance Newspaper Website PCP Other

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize Allergy, Asthma & Dermatology Associates, PC and the above physician to release to the insurance company named above any information acquired in the course of my examination or treatment.

SIGNED _____
(if patient is a minor, signed by parent or guardian)

ASSIGNMENT OF INSURANCE BENEFITS: I hereby agree to full responsibility for all expenses incurred by or on account of this patient and hereby assign to Allergy, Asthma & Dermatology Associates PC any and all insurance benefits due me to the fullest extent of my financial obligation to said office.

SIGNED _____
(if patient is a minor, signed by parent or guardian)

VERIFICATION OF INSURANCE AND RESPONSIBILITY

Date/Initials _____ Date/Initials _____ Date/Initials _____ Date/Initials _____ Date/Initials _____ Date/Initials _____

OFFICE USE ONLY

Clinic _____ Deposit _____ Co-pay _____ Family Established Y / N Referral Y / N Initial/Date _____