The solo pediatric practices of
Magdalenne Corso MD, PC; James Resk, MD, PC; Troy Stoeber, MD, LLC; Kristine Bugakov MD, LLC
14279 Glen Oak Road, Oregon City, OR 97045 ❖ 503 657-7629 ❖ 503 557-8651 *fax*

FINANCIAL POLICY

We are independent physicians who share employees, an office building, services and policies. The intent of this communication is to explain our *Financial Policy.* Not only are we committed to providing excellent pediatric care to your child, we are committed to providing you with information so you can make informed decisions regarding financial matters.

- All practices accept payment by cash, debit, VISA and MasterCard.
- Co-pays are collected upon appointment check-in. Your insurance carrier requires this collection of monies. A fee of $10.00 will be added to your account if co-pay is not received at the time of appointment.
- Private-pay accounts (no insurance) qualify for a 20% discount when charges are paid at time of service. For office visits and well checks only.
- Private-pay (no insurance) payment-in-full is expected at the time of service for the first appointment, and for appointments thereafter unless there are arrangements made with the Business Office prior to receiving services.
- Non-covered services, such as circumcision and tongue clipping, will be collected at time of service
- A charge of $25.00 for returned checks will be assessed.
- For non-canceled appointments without at least a notice of one (1) day, a $50.00 fee will be assessed. For any more than three (3) non-cancellations in a calendar year, the patient relationship with the physician may be terminated.
- We will bill your claims for you with your insurance company. However, please note, after insurance has processed your claim(s) payment of the balance in full is expected within 30 days unless arrangements have been made with the Business Office.
- A Billing Office representative is available during regular business hours to discuss payment arrangements and/or ask questions regarding your account. Please contact them directly at (503) 657-0190.
- By signing this form, **I understand** that I am responsible for all charges whether or not covered by insurance and that all co-pays are due at the time of service.
- By signing this form, **I authorize** my insurance plan to make direct payment of medical benefits, to include major medical benefits, to Drs. Corso, Resk, Stoeber and/or Bugakov.

IF INSURANCE CARDS ARE NOT PRESENTED AT EACH VISIT YOU MAY BE CONSIDERED SELF-PAY

I have read this Financial Policy and understand that I am responsible for the payment of my account within the limits of this Policy regardless of insurance coverage. By signing this agreement, I agree to pay all costs and reasonable attorney fees if suit is instituted to collect monies owed by me, including interest charges, processing fees or commissions that may be assessed by any collection agency retained to pursue this matter.

______________________	______________________	______________________
Name of Patient	Date of Birth	Today's Date
______________________	______________________	______________________
Name of Parent/Legal Guardian	Signature of Parent/Legal Guardian	Relationship to Patient