RestorePDX
FUNCTION-PERFORMANCE-LIFE

INTERVENTIONAL SPORTS AND SPINE

Authorization For Release Of Health Information

Please answer the following three questions regarding the release and disclosure of your medical and billing information. Please return the completed form (signed and dated) to the front desk.

Do we, RestorePDX, have your permission to release your medical information to your healthcare providers? ☐ Yes ☐ No

Do we, RestorePDX, have your permission to obtain your medical information from your healthcare providers? ☐ Yes ☐ No

Please list all family member(s)/guardian(s) that may access your medical records and/or financial and billing information. Please list ALL.

Name of Person	Relationship	Medical Only	Billing Only	Both
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐

Printed Patient Name

Patient's Date of Birth

Signature of Patient

Date

Signature of Parent/Guardian

Relationship to Patient

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Financial Policy, Assignment of Benefits, and Receipt of Notice of Privacy Practices

If you have insurance, RestorePDX will gladly process your claim. However, we require that your estimated portion is paid when services are rendered. IF YOU ARE NOT COVERED BY INSURANCE, we will provide an estimate of the cost of your care. This estimate will include anticipated charges based on the recommended treatment plan. If your plan of treatment changes, you may be asked to agree to a new estimate and estimates may vary due to a variety of factors.

If you are a SELF-PAY patient, or if you have a financial obligation after your insurance has fulfilled its responsibility, you will be expected to pay the balance due in a reasonable time. For payment options, you must speak with our Business Office. For further understanding of our billing process, please feel free to contact the business office staff.

Please Initial:

_____ I request that payment of authorized insurance benefits be made on my behalf to RestorePDX for all pharmaceuticals, tests, procedures, equipment, supplies, physician/nursing services—including major medical benefits, for services provided to me by RestorePDX.

_____ I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for the above mentioned medical services to RestorePDX, my insurance carrier, state, federal accreditation agency, or other medical entity.

_____ It is my responsibility to notify RestorePDX of any changes in my healthcare coverage, insurance carrier, change of address, change of employer or any change in legal guardianship of the minor/patient.

_____ I understand that I am financially responsible to RestorePDX for any charges not covered by health care benefits. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by RestorePDX and/or my health care insurer. If the submitted claims, or any part of them, are denied for payment, I understand that by signing this form I am accepting financial responsibility and am agreeing to pay for any/all above described medical services received. I acknowledge this document as a legally binding assignment to collect by benefits as payment of claims for services.

_____ I understand that there is a $25.00 charge for all returned checks.

_____ I understand that there is a $50.00 charge for all missed or cancelled appointments that are not cancelled before 24 hours of the scheduled appointment time.

THIS ASSIGNMENT/ACKNOWLEDGEMENT WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING

By signing this document, I acknowledge that I have been made aware of RestorePDX's Notice of Privacy Practices, as it is required by the Health Insurance Portability and Accountability Act (HIPAA) to ensure that I have been made aware of my privacy rights as well as Understanding our Billing Process. I have read and, if requested, received a copy of the above statement and Privacy Practices and accept the terms. A duplicate of facsimile transmission of this statement is considered the same as the original.

Signature of Insured/Parent/Guardian _____Date_____

Print Name of Insured/Parent/Guardian _____

Employee Witness _____