David L. Chamberland, MD, INC
DGS Rheumatology PC
Rheumatology Clinic, LLC
1365 Poplar Drive
Medford, OR 97504-5207
Business Office: (541) 245-6012

COLLECTION POLICY

PROMISE TO PAY
Installment note

I PROMISE TO PAY (circle one) Southern Oregon Rheumatology Clinic

1. **Collection policy:** Co-pays are due at time of service. If unable to pay all other estimated charges at time of service 25% down payment and minimum monthly payments of 25% due by the end of each month. *Account balances of $100 or less require minimum payment of $25 per month*.

2. **Uninsured Policy:** *Payment made in full at time of service* receives a 25% discount. If unable to pay in full 25% down and minimum monthly payments of 25% due by end of each Month.

3. **24 hour cancellation policy** – If you no show for your appointment you will be charged $45. This policy is in place out of respect for our physicians and their patients. Cancellation without 24 hours notice is difficult to fill. By giving last minute notice or no notice at all, your prevent someone else from being able to schedule. By initialing you acknowledge you have read and understand the cancellation policy as described above. _____

4. Auto-payment is available for Visa/MasterCard and Discover. Inquire with bookkeeping department

5. Financial hardship is available. Patient must complete hardship paperwork and supply copy of previous year's tax return before any changes can be made to the cash policy.

Waiver of Responsibility:

Some out of state BlueCross plans *do not cover services rendered in Oregon. You can choose to pay at time of service to receive the above discount or we can bill your insurance and you will not be eligible for a discount if your insurance denies.*

TriWest Health Alliance or VA insurance: We are not contracted with TriWest or the VA and do not accept this insurance. By initialing you are certifying 1) **you do not have this insurance** or 2) you are aware of our policy and that you are responsible for billing and obtaining your own authorizations. _____

_____ _____
(Printed) Patient – Last Name, First Name, MI Signature of patient or person authorized by law

_____ _____
Permanent Street Address Witness Signature

_____ _____
City, State, Zip Date Signed

This policy is subject to change at the Rheumatology Clinic's discretion.

CC: Chart, Patient Revised 10/22