

Regenerative Sports & Spine Center

7654 SW Mohawk Street
Tualatin, OR 97062
Phn 503 691-2000 Fax 503 691-2001

Name: _____ DOB: _____

MRN: _____

Financial Agreement and Release of Information

Please read and sign the following consents, releases, and agreements.

1. **RELEASE OF INFORMATION:** To obtain payment for services, the undersigned hereby authorizes the clinic to furnish from the patient's record, requested information or excerpts to any insurer, employer, or union which processes claims for the patient's care.
2. **FINANCIAL AGREEMENT:** Billing of your insurance is done as a courtesy for you, but we hold you responsible for your account and to be financially responsible for charges not covered by insurance. Co- payments and Co-insurances are due at the time of your office visit. Accounts that are 90 days old are considered delinquent and a finance charge of \$3.00 per month will be added to cover the cost of additional handling.
3. **LATE FEES:** visits and procedures that are not given an adequate 24 hour notice will be charge a late/no-show fee. New visits - \$100.00, follow up visits - \$50.00, procedures - \$200.00
4. **DEPOSITS:** a deposit maybe required for certain regenerative procedures, if you no-show your procedure, the deposit will be forfeited.

Consent to Release Health Information

As a patient of the Sports & Spine Center, PC., I understand that my health information may include information both created and received by the practice, which may be in the form of written or electronic records or spoken work, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

By my signature of that of my representative below, I agree and understand that the Sports & Spine Center, PC may use and disclose my health information for such typical purposes of:

1. Treatment, including providing, coordinating, managing, making decisions about and planning for my care and treatment: referring to, consulting with, coordinating among and managing along with other healthcare providers for my care and treatment.
2. Payment, including determining my eligibility for health plan or insurance coverage and benefits, submitting bill to health plans, insurers and others who may be responsible to pay for some or all of my health care; and
3. Health Care Operations, including performing various office, administrative, and business functions that support the Sports & Spine Center efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

Patient's Signature: _____ Date: _____

Patient Name: _____ Date: _____

Guardian's Signature (if patient under 18): _____

Relation to Patient: _____

Signed By (Other than patient): _____