Dear New Patient,

Welcome to our practice! Thank you for allowing us to serve your dermatology needs. The following information is provided to ensure a smooth transition into our practice.

Please complete the forms and bring them with you to your first appointment, it will help speed up the check-in process. You will need to arrive 15 minutes prior, so that we are able to have your chart ready by your appointment time.

If you have medical insurance, please bring all of your current insurance and a valid photo identification card with you at the time of your appointment. Please check to make sure that your cards are not expired. This will help complete your chart.

Plan on bringing any required copayments to your office visit and it will be collected at the time of check in. For self-pay patients, payment in full at the time of service is required, unless discussed otherwise. We accept cash, checks, and all major credit cards.

Thank you! We look forward to meeting you soon.

Sincerely,

The Team at Clear Choice Dermatology

The Dalles / Hood River / Goldendale: (541) 316-6575
Lake Oswego: (503) 905-9006
Salem/Hillsboro/Warrenton: (503) 905-9006

The Dalles: 1815 East 19th Street, Suite B The Dalles, OR 97058

Hood River: 1750 12th Street Hood River, OR 97031 (Cascade Orthopedics & Sports Medicine Center)

Goldendale: 310 S Roosevelt Ave, Goldendale, WA 98620 (Klickitat Valley Health - Family Medicine)

Lake Oswego: 123 C Avenue, Lake Oswego, OR 97034

Salem: 1610 12th St. SE, Salem, OR 97302

Hillsboro: 256 SE 2nd Ave, Hillsboro, OR 97123 (Well Life Medicine)

Warrenton: 1609 S. Main Ave., Warrenton OR 97146

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PATIENT INFORMATION

NAME (First, M.I., Last):

DOB: | AGE: | SEX: □ Male □ Female □ Other _____ | SSN: _ _

RACE / ETHNICITY:
□ Prefer not to answer
□ Black / African American
□ White / Caucasian
□ Not sure
□ Other _____
□ Asian or Pacific Islander
□ Native American
□ Hispanic / Latino

PREFERRED LANGUAGE:
□ English
□ Spanish
□ Other _____

ADDRESS (City, State, Zip):

PRIMARY PHONE:
□ Cell
□ Home

SECONDARY PHONE:
□ Cell
□ Home

EMAIL ADDRESS:
(Please PRINT CLEARLY!)

MARITAL STATUS: □ Single □ Married □ Widowed □ Divorced

EMERGENCY CONTACT:
□ Parent/Legal Guardian of Patient

Name (First, Last):

Phone:

Relationship to Patient:

PRIMARY CARE PROVIDER / CLINIC NAME:
□ I don't have one

OCCUPATION (optional):

PARENT / LEGAL GUARDIAN INFORMATION (IF PATIENT IS A MINOR)

RESPONSIBLE PARTY'S NAME (First, Last):

DOB: | SSN: _ _

ADDRESS (City, State, Zip):
□ Same as Patient's Address Above

INSURANCE INFORMATION

PRIMARY INSURANCE NAME:

POLICY HOLDER'S NAME (if different from patient):

DOB: | Relationship to Patient:

SECONDARY INSURANCE NAME:

POLICY HOLDER'S NAME (if different from patient):

DOB: | Relationship to Patient:

How did you hear about us?
□ Insurance
□ Primary Care Referral
□ Street Sign
□ Internet Search
□ Internet Ad
□ Our Website £
□ ZocDoc.com
□ Healthgrades.com
□ Friend/Family
□ Instagram
□ Yelp
□ Facebook
□ Other: _____

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CONSENT TO DISCLOSE HEALTH INFORMATION

	Name	Adress/Intersection	Phone
No☐ YES☐ Primary Care Physician			
No☐ YES☐ Referring Physician			
No☐ YES☐ Pharmacy			

I give Clear Choice Dermatology, their clinicians (physicians, NPs, PAs) and staff, authorization to disclose my protected health information to the following family, friends, and/or caregivers:

Relationship	Name	Phone

In the event Clear Choice Dermatology may need to communicate your test results or medical information via telephone, please check all communication options below that may be used:

☐ Leave a detailed voice message on your: ☐ Cell phone ☐ Home phone ☐ Other: _____

☐ Call you at the following numbers: ☐ cell phone ☐ Home phone ☐ Other: _____

☐ Only speak to **YOU** directly

**THE AUTHORIZATION IN THIS FORM EXPIRES: ☐ Never ☐ 1 year from today:

Please check and sign only ONE of the following:

☐ **I allow Clear Choice Dermatology to share my sensitive health information as noted above per the communication options checked on this form.**

☐ **I DO NOT allow Clear Choice Dermatology to share my sensitive health information with anyone but myself.**

My contact information below is up to date (If patient is minor, enter Guardian information):

PATIENT NAME: **DOB**

MAILING ADDRESS **PHONE #**

_____ *Patient/*

Guardian Name *Signature* *Date*

GUARDIAN NAME:_____ **PHONE #**_____ **RELATIONSHIP** _____

By signing above, I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to information shared in the process of treatment, payment or healthcare operations as cited in the Notice of Privacy Practices.

I understand that authorizing the disclosure of this health information is voluntary. Clear Choice Dermatology and its entities will not condition treatment, payment, enrollment, or eligibility for benefits on providing, or refusing to provide this authorization. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by Federal Confidentiality Rules. If I have questions about the disclosure of my health information, I can refer to my Notice of Privacy Practices. *PLEASE ASK US IF YOU WOULD LIKE A COPY OF OUR PRIVACY PRACTICE POLICY

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MEDICATIONS			
□ I am NOT taking any medications			
Name	Strength	Dosage Frequency	Reason

PHARMACY: (Name & Location)	

ALLERGIES	
□ I have NO known allergies	
Medication/Allergen Name	Type of Reaction

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SKIN CANCER HISTORY	
Do you have a PERSONAL history of:	☐ Skin Cancer ☐ Melanoma ☐ Squamous Cell Carcinoma ☐ Basal Cell Carcinoma ☐ None of the above
Do you have a FAMILY history of:	☐ Skin Cancer ☐ Melanoma ☐ Squamous Cell Carcinoma ☐ Basal Cell Carcinoma ☐ None of the above

GENERAL MEDICAL HISTORY	
Please list all *other* past and current medical conditions below:	

SURGICAL HISTORY	
Surgery Name	Date
☐ Mohs Surgery Location:	
☐ Skin Cancer Surgery Location:	

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REASON FOR VISIT

Name:	DOB:

If you are only here for a routine skin exam, please skip to MEDICAL CHECKLIST

Severity of Problem: □ Mild □ Moderate □ Severe

Type of Problem: □ Rash □ Lesion □ Spot □ Mole □ Wart
□ Acne £ Cyst □ Ulcer □ Scar □ Blister
□ Skin Tag £ Discoloration □ Other _____

Symptom(s) associated with problem: □ Painful □ Itchy □ Burning □ Stinging
□ Bleeding □ Unsightly □ Spreading □ Tingling
□ Other _____

Area(s) of body affected: □ Scalp □ Face □ Ear □ Neck
□ Chest □ Back □ Abdomen □ Nails
□ Right Upper Extremity □ Left Upper Extremity
□ Right Lower Extremity □ Left Lower Extremity

How long has it been present? _____

Treatment used for condition: □ YES □ NO

MEDICAL CHECKLIST

Do you have a bleeding disorder?	□ YES	□ NO
Are you taking any blood thinners?	□ YES	□ NO
Do you have a pacemaker/defibrillator?	□ YES	□ NO
Frequent sun exposure?	□ YES	□ NO
Are you currently suffering from seasonal allergies?	□ YES	□ NO

Do you drink alcohol? □ YES: _____ drinks per □ Day □ Week □ NO

Are you a current or former smoker? □ YES: _____ packs per day Quit Date _____ _____ years of smoking □ NO

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MIPS DOCUMENTATION EVERY 3 MONTHS *(Q#XXX- OFFICE USE ONLY)*

MIPS ARE A GOVERNMENT REQUIRED PROGRAM DESIGNED TO PROVIDE OUR PATIENTS WITH THE BEST CARE POSSIBLE.
WE APPRECIATE YOU UPDATING MIPS EVERY 3 MONTHS.

PATIENT NAME:_____ **DATE OF BIRTH:** _____

- **Can we send your Biopsy Results to your Primary Care Physician?**
- ☐ **No,** ☐I don't have a PCP ☐Refuse ☐Other:_____ ☐ **Yes, PCP Name:** _____

*(Q265- Biopsy) YES→✓ **FAX/ED** Path to PCP | ✓ **SELECT** Biopsy result communicated | **NO** ✓→**DOCUMENT** in patient Chart Note why | ✓ **SELECT MIPS**: Documentation of patient….*

- **Do you have Melanoma or a History?** ☐ **No(N/A)** ☐ **Yes,:** Diagnosed ☐< 6mth ago ☐> 6 month ago Date/s:_____
  - **If Yes,** are you being monitored every 3/6 month? ☐ **No,** WHY?_____ ☐ **Yes,** Provider Name: _____

*(Q137MM) NO→ ✓ **Enter Chart Note Reason-** ✓ **SELECT MIPS Document Reason (NO) (YES→✓ PCP** is chart **| ✓ CREATE** Recall: **<1y →3mth F/U MM OR < 2 y →6 MTh F/U MM ✓| SELECT MIPS: PT INTO RECALL**
(Q138- MM) NO→✓ SELECT MIPS Appropriate Option **| YES→** ✓ PCP **ENTERED** IN EMA **→✓ SELECT MIPS** Treatment Plan was communicated|**(Q379**) ✓ **UPDATE CANCER LOG** | ✓ **SELECT MIPS A**ppropriate Option*

- **Do you smoke Tobacco?** ☐ **No** ☐ **Former** ☐ **Yes**

*(Q226) ✓ **SOCIAL HISTORY:** ENTER SMOKING STATUS **| ✓ VISIT NOTE→ IMPRESSION>**Tobacco use disorder**>| PLAN>**Counseling **(PROVIDER)>** PT EDUCATION: QUIT SMOKING GIVEN TO PATIENT BY PROVIDER ✓ **SELECT MIPS** PT SCREENED FOR TOBACCO | ✓ **SELECT MIPS NO/FORMER** →Pt screened for Tobacco use and is an ex/no smoker | **YES** → Pt screened for Tobacco use and counseled*

- **Did you provide or review your current medication list?** ☐ **No** ☐ **Yes (Name, Dose, Frequency, Route of Administration)**

*(Q337 MEDS) ✓ **NO→** UPDATE LIST | ✓ **YES→** ✓ **MUST ENTER** DOSAGE, FREQUENCY, ROUTE of all meds in Clipboard | ✓ **SELECT MIPS** Current Medications Documented*
FD→** PRINT MEDICATION LIST→APPOINTMENT FLOW→ SELECT PATIENT → CLIPBOARD →MEDICATIONS →PRINT ACTIVE MEDS→**ASK PT AT EVERY OFFICE VISI AND UPDATE

- **Have you received a flu vaccine since September 2021?** ☐ **No,** WHY?_____ ☐Refuse ☐Allergies ☐Pending (Will do) ☐ **Yes**

*(Q110 IMMUNIZED) ✓ **SELECT MIPS YES →** Immunization given during flu season **|NO→**Immunization was not ordered or administered, reason not given |**NO/PENDING →ASK PT AT EVERY VISIT AND UPDATE***

- **Have you received a pneumonia vaccine?** ☐ **No,** WHY?_____ ☐Refuse ☐Allergies ☐Pending (Will do) ☐ **Yes**

*(Q111) **SELECT MIPS** ✓ **YES** → Pneumococcal vaccination previously received | **No** →Pneumococcal vaccination no received, reason not specified **NO/PENDING →ASK PT AT EVERY VISIT AND UPDATE***

- **Do you have an Advance Care Plan?** ☐ **No** ☐ **Yes - If yes, answer below**

*(Q47) ✓ **ADVANCE CARE PLAN:** ENTER INFORMATION PROVIDED | ✓ **SELECT MIPS YES →** Advance care plan document. **NO →**Patient did not wish or unable to provide advance care plan*

  - Do you wish to have full cardiopulmonary resuscitation efforts? ☐ **No** ☐ **Yes**YES→ "full code"
  - Do you wish to have a breathing tube if it is required for life saving measures? ☐ **No** ☐ **Yes**NO→"Do not intubate"
  - I do **not** want to be resuscitated even if it is required for life saving measures? ☐ **No** ☐ **Yes**YES→"Do not resuscitate"
  - Do you have a living will? ☐ **No** ☐ **Yes**YES→"Livingwill"
  - Do you have a health care surrogate? ☐ **No** ☐ **Yes**YES→"Healthcare proxy"
  - What is the health care surrogate's name _____

- **Are you taking Skyrizi, Humira, Dupixent, Taltz, Consenyx, or Stelara?**:

*(Q410) ✓ **SELECT MIPS** ✓ **No→ SELECT** Appropriate Option*

☐ **No,** WHY? ☐ **N/A** ☐ **Declined** ☐ **Contraindications** ☐ **Other**_____

*(Q410) ✓ **SELECT MIPS YES** pt on >6mth **OR** Psoriasis Tools Documented | ✓ VISIT **NOTE→DOCUMENT** tools and specified benchmark met*

☐ **Yes: Started:** ☐< 6 MTh ago ☐> 6 MTh ago ☐ **Therapy Change Request**

- **TB Test Results:**_____
- ☐ **Negative(1)** ☐**Positive w/no evidence(2)**
- ☐**No Results of TB Screen- Reason:**_____ **(3-)** ☐ **Unknown(4-Document in Pt Chart Note)**

*(Q337)**YES/✓ NEGATIVE(1)** → Patient has a documented negative TB test screening prior to treatment OR (2)No Evidence OR (3) **(4)** ✓* Document in Pt Chart Note

FINANCIAL POLICY

Thank you for choosing Clear Choice Dermatology. We are dedicated to providing the best possible care and services for you. Knowing your financial responsibility is an essential part of your care. Please read the following carefully.

No Surprises Act of 2022: In accordance with the No Surprises Act of 2022, I understand that it is my responsibility to see participating providers within my plan. Should my plan not be participating with Clear Choice Dermatology or a provider of Clear Choice Dermatology, and I receive medical services, I understand that I will be billed the Out of Network patient responsibility or non-participating balances as they pertain to services provided.

Insurance: It is the responsibility of the patient to provide accurate insurance and personal information. Accepting your insurance does not place all financial responsibilities onto this practice, and you will be held accountable for any unpaid balances by your plan. Although we are contracted with most insurance carriers, our services may not be covered by your insurance plan. Being referred to our office by another physician does not guarantee that your insurance will cover our services.

Co-Pays and Outstanding Balances: It is the policy of Clear Choice Dermatology that payment is due at the time of service. Co-Pays must be paid in full. All balances on your account must be paid prior to, or at the time of your visit. This includes but is not limited to co-insurance and deductibles. If you cannot pay your balance at the time of visit, you will need to reschedule your appointment. Our office does not offer payment plans currently.

Self-Pay and Cosmetic Appointments: Payment is expected in full at the time of service.

Cancellations and Missed Appointments: Office Visits: I understand that it is my responsibility to cancel my appointment at least 24 hours before the scheduled date and time; otherwise, a $50.00 fee will be billed to my account, which will not be covered by my insurance plan. All outstanding balances must be paid in full before your next visit.
Surgical Appointments: I understand that it is my responsibility to cancel my appointment at least 24 hours before the scheduled date and time; otherwise, a $200.00 fee will be billed to my account, which will not be covered by my insurance plan. All outstanding balances must be paid in full before your next visit.
We understand that unexpected life events and illnesses do occur. If this happens, please call our office as soon as possible to cancel or reschedule your appointment.

Referrals: If your insurance requires a referral, it is your responsibility to provide the referral *prior to your visit.*

Pathology: On occasion, pathology is ordered by physicians to properly diagnose certain skin disorders. To provide quality care for our patients, we utilize an independent licensed lab with analysis performed by a Board-Certified Dermatopathologist who specializes in the microscopic diagnoses of skin disorders. Charges for these services are in addition to your office visit and procedure charge.

Requests for Medical Records: There is a $25.00 fee for medical records, plus the cost of mailing and/or electronic device. FMLA, medical, and other such policy forms that need to be filled out by our office will require a $10.00 fee. These fees must be paid before the records/forms are sent.

Accepted Payment Methods: Clear Choice Dermatology accepts cash, Visa, Mastercard, Discover, and personal checks with proper identification (valid Driver's License or photo ID), checks can be made payable to "Clear Choice Dermatology". There will be a $30.00 charge for any returned checks.

REFUNDS: Credit balances that are below $25.00 will remain on the patients account for future use of either services or product. Refunds will be issued on any credit balances that are over $25.00 that are requested either verbally or in writing. Refund requests will be processed by the CFO/Accounting and forwarded once completed and can take up to 60 days for completion.

ACKNOWLEDGEMENT OF FINANCIAL POLICIES: I have read the above financial policies and understand my financial responsibilities as a patient at Clear Choice Dermatology. I understand that failure to make a payment when due is the basis for legal action and agree to pay all costs of collection, including court costs and attorney fees. A collection fee of 30% will be added to unpaid invoices for which the balance has been transferred to our collection agency. If I do not sign this consent, Clear Choice Dermatology may decline to provide treatment to me.

AUTHORIZATION TO RELEASE MEDICAL RECORDS: I hereby authorize Clear Choice Dermatology, LLC to release any medical information required in the course of examination and treatment and permit payment directly to them any benefits due for their services rendered. I recognize and accept responsibility for services rendered regardless of insurance coverage. This includes, but is not limited to, co-payment, co- insurance, deductible, and non-covered services.

ACKNOWLEDGEMENT OF PRIVACY POLICY: I acknowledge that I have been advised of Clear Choice Dermatology Notice of Privacy Policy (NOPP) by being offered to take a physical copy of Clear Choice Dermatology Privacy Policy (available at the front desk) OR view it online at clearchoicederm.com

FOR MEDICARE PATIENTS ONLY: I request that payment of authorized Medicare benefits be made either to me or on my behalf Clear Choice Dermatology, LLC for any services furnished to me by their providers. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Name of Patient

Name of Patient or Responsible Party

Relationship to Patient

Signature

Date

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HIPAA POLICY

We understand information about you, your healthcare and your health are personal. We are committed to protecting your personal health information (PHI). We keep a record of your health to provide you with quality care and to comply with certain legal requirements. We are required by law to:

O Make sure health information about you is kept private

O Give you this notice of our legal duties and privacy with respect to your PHI O

Follow the terms of this notice

We provide a record of the care you receive. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all records of your care generated by this practice and tells you the ways in which we may disclose your information.

Treatment: We may use your health information to provide you with treatments or services. We may disclose your health information to physicians, nurses, technicians or other personnel who are involved with your care.

Payments: We may use and disclose information about treatments and services for billing purposes. These fees may be collected from you, your insurance or a third party.

Appointment Reminders, Communication, Mailers, Medical Information: We may use and disclose health information to contact you to remind you of any upcoming or missed appointments, communicate with you, or send you some information about our Practice. If you do not wish to have us contact you for this purpose or if you wish for us to use a different address or phone number for this purpose, complete the HIPAA section on the patient registration form.

By law, we are only permitted to discuss your diagnosis and treatment with you (the patient/Guardian). However, we may release your medical information to your immediate family upon their request. In the event a spouse, family member, or close friend may need this information, please provide us with their name, relationship and phone number. We will keep this information as your emergency contact and remove it upon your written request. If you do not wish us to disclose any information to your immediate family, complete the HIPAA section on the patient registration form.

We disclose your health information when required by federal, state, or local law. If you are involved in a lawsuit or a dispute, we may disclose your health information in response to a court or administration order.

• Right to inspect and copy: You have the right to inspect and copy your health information to include billing.

• Right to a summary or explanation and to Amend: If you believe that your health information is incorrect or incomplete, you may ask us to amend the information.

• Right to Request Restrictions: You have the right to request a restriction of limitations about your health information use, treatments or health operations.

• Object and Opt Out: You have the right to object and opt out of the use and disclosures to individuals involved in your care or payment for your care, disaster relief and fundraising activities.

• Complaints: If you believe your privacy has been violated, you may file a complaint with our privacy officer or the secretary of The Department of Health and Human Services in Washington, D.C.

• Right to an electronic copy of your medical records, get notice of breach, accounting of disclosures, request confidential communications, out-of-pocket payments (if you do not wish us to bill your insurance), and right to receive a paper copy of this Notice. This authorization may be revoked at any time to the extent that use, or disclosure has not already occurred prior to your request. To update/revoke the authorization, notify the Privacy Officer in writing or by phone Clear Choice Lockbox, PO Box 84611, Seattle, WA 98124-5911 | 541-316-6575

Name of Patient or Responsible Party _____ Relationship to Patient _____

Signature _____ Date _____

PATIENT BILLING CONSENT FORM

If you are a minor, uninsured, insured with a non- participating insurance (including non-QMB Medicaid patients), have an outstanding balance or had a past delinquent account, please fill out the form below.

Patient Name: _____ Date of Birth _____

IF PATIENT IS UNABLE TO CONSENT, GUARDIAN/PARENT MUST COMPLETE THE FOLLOWING:

Patient is unable to consent because:_____ I hereby consent on his/her behalf and in his/her stead. I am responsible for any medical expenses incurred by this patient ∆ YES ∆ NO.

Name:_____ Relationship to patient: _____
First Name Middle Last Name

Date of Birth:___/___/____ Social Security Number:_____ Primary Phone Number: _____
Month Date Year

Billing Address:_____ City / State: _____ Zip code: _____

Please present your photo ID to the receptionist. *Used for identification purposes and for protection of your Private Health Information.*

Signature:_____ Date: _____

I authorize Clear Choice Dermatology to charge my Credit card for professional services as follows:

- ❑ Full Fee for Service $_____
- ❑ Co-pay Amount or Fees towards Insurance Deductible $_____
- ❑ Outstanding Balance $_____
- ❑ Other $_____ - Description: _____

Special Note:_____

Please be aware that unless an agreement is negotiated with the above provider all outstanding balances not paid within 30 days, after a bill is sent or the insurance company has notified you or this office of your balance, will be charged to your credit card.

Card Holder's Signature:_____ Date: _____

Please note that all information will be kept confidential and that information will only be used to obtain payment for services.

Credit Card on File Agreement

Clear Choice Dermatology has implemented a new credit card policy. Recent changes in healthcare markets and payment processes have altered insurance coverages to shift more of the cost of care to our patients. The credit card on file policy is a convenient method to pay for the portion of services that are deemed patient's responsibility, such as copay, deductible, and co-insurance.

Co-pays and remaining deductibles are still due at the time of the visit. At check-in, the credit card information will be obtained and kept confidential and secure until the insurance(s) have paid their portion and notifies Clear Choice Dermatology of the balance due, if any. At that time, the billing department will issue out one statement via mail which the patient will have 30 days to pay or make other forms of payment arrangements. After 30 days, the debit/credit card on file will be automatically charged for any outstanding balance. In the case when a credit card has reached its limit maximum, the patient will have an additional 30 days to arrange payment before the bill is forwarded to a collection agency.

I authorize Clear Choice Dermatology to keep my debit/credit card on file and to charge my debit/credit card for any outstanding balances that my health plan has identified as my financial responsibility. If the provided debit/credit card has changed, expired, or denied for any reason, I agree to immediately give Clear Choice Dermatology a new, valid debit/credit card which I will allow to be charged over the phone. I agree that the new card can be saved and used with the same authorization as the original card I presented.

☐ **Visa**	☐ **MasterCard**	☐ **Discover**	☐ **American Express**
Patient's Name (print):			
Date of Birth (mm/dd/yyyy):			
Cardholder Name (print):			
Last Four Digits of Debit/Credit Card Number:		Exp. Date:	
Card Billing Address:			
☐ Please check this box if you prefer not to receive a statement and would like us to bill your debit/credit card immediately for any balances due after the processing of your insurance.			

Debit/Credit Card Holder's Signature:_____Date: _____

Authorization Received by:_____(Initials) Date: _

Frequently Asked Questions Regarding Credit Card on File

1. **Do I have to leave my credit card information to be a patient?**

   Yes. This is our policy and it is a growing trend in the healthcare industry. Insurance reimbursements are declining and there has been a large increase in patient deductibles and patient responsibilities.

2. **What are the benefits?**

   It saves you time and eliminates the need to write checks, buy stamps or worry about delays in the mail. It also drives administrative costs down because the billing department will send out fewer statements and spend less time taking credit card information over the phone or entering it from the billing slips sent in the mail, which are less secure methods than us storing the information. The extra time can now be spent on helping patients directly in person or over the phone.

3. **I always pay my bills on time. Why do I have to do this?**

   The billing process is time-consuming and wasteful. Reducing unnecessary costs are essential to allowing us to continue to be an in-network provider with most insurance companies. Nothing is changing about how much you end up paying.

4. **What if I don't have a credit card?**

   It is our policy that payment is due at the time of service. You may also keep your Health Savings Account (HSA) or Flex Spending Account (FSA) credit cards on file. If you do not have either of these types of cards, then you can use a debit or credit card. We accept Visa, Mastercard, American Express, and Discover.

5. **How can I be assured that my credit card information will remain safe?**

   We are under the strict rules and guidelines of Payment Card Industry (PCI) Compliance, and HIPAA Compliance to protect patient privacy and credit card information is considered protected health information. We use the same methods to guard your credit card information as we do for your medical information. The card information is securely protected by the credit card processing component of our HIPAA compliant practice management system. We cannot see the card number – only the last four numbers, giving us no way to use the card outside of the billing system. Our employees will not have access to your bank card.

6. **What if there is a payment discrepancy or I have other payment questions?**

   Please contact our billing department directly, (541) 316-6575, to settle payment discrepancies or for other payment questions. This policy is in no way compromising your ability to dispute a charge or to question your insurance company's explanation of benefits.