PAUL M. PUZISS, M.D., P.C.

PHYSICIAN AND SURGEON
ORTHOPEDIC SURGERY SHOULDER CLINIC OF PORTLAND
3800 S.W. CEDAR HILLS BOULEVARD, #250
BEAVERTON, OREGON 97005
(503) 646-8995
Fax (503) 644-4678

Diplomate American
Board of Orthopedic
Surgery

FINANCIAL AGREEMENT

We are pleased that you have chosen Dr. Paul M. Puziss for your orthopedic care. Our goal is to provide the highest quality medical care. The following credit and payment policies have been established to assist us in achieving this goal.

IF YOU HAVE INSURANCE: Please provide your insurance card(s) at the time of service. We will submit claims to your insurance carrier(s) on your behalf. Please note that the contract for your benefits is between you and your insurance carrier and questions or concerns about your coverage should be handled directly with them. Any balance remaining after payment from your insurance company(ies) is due within 30 days after receipt of your statement. Co-payments are due at the time of service along with payment for services not covered by your insurance.

IF YOUR INSURANCE REQUIRES A REFERRAL TO SEE A SPECIALIST: Your insurance carrier may require a referral for you to see Dr. Puziss. If so, it is the patient's responsibility to have acquired this **BEFORE** your appointment. If this is not possible, you will need to sign a waiver of responsibility or be asked to reschedule your appointment until it can be done.

IF YOU DO NOT HAVE INSURANCE: Payment for services is expected at the time of service. We will calculate your charges at the end of your visit. There is a *10%* discount for cash payment with the exception of any medical legal charge.

WORK-RELATED, AUTO, AND THIRD PARTY CLAIMS: Please provide the receptionist with the name of your insurance carrier, the date of the accident, name and address of your employer at the time of injury, and claim number. Any questions about your coverage should be handled directly with your insurance carrier. We cannot postpone payment until the settlement of these claims. We also cannot be responsible for resolving any disputes about your claim(s).

BROKEN OR CANCELED APPOINTMENTS: Please notify our office 24 hours in advance to cancel or reschedule your appointment. You may leave a message with our answering service after hours or on weekends for unforeseen events. A cancellation fee for appointments that are canceled or broken without required notice is $150.00, which is not payable by your insurance company.

TERMINATION OF DOCTOR-PATIENT RELATIONSHIP: Dr. Puziss reserves the right to terminate his relationship with any patient. Usual causes for this may include "no shows" for scheduled appointments, abuse of narcotic medications, and inappropriate behavior toward the doctor and his staff. Fortunately, terminating a relationship is a rare occurrence.

FINANCIAL RESPONSIBILITY: The patient is financially responsible for services rendered. Dr. Puziss reserves the right to reschedule an appointment if the patient is unable to make payments required at the time of service. A fee of $25.00 will be assessed for any checks returned for insufficient funds. If you are unable to pay the amount due at the time of service, you can discuss other possible arrangements with our bookkeeper—(503) 526-8814.

We accept personal checks, cash, and credit cards. Failure to meet financial responsibility may result in collection action.

I have read and understand the above policies for Paul M. Puziss, M.D. I accept these policies and agree to abide by the terms stated above.

____
Name

____
Date