



School of Dentistry Student and Resident Clinics and Russell Street Clinic
Financial Policies Consent

It is important that patients understand and agree to our financial policies prior to starting treatment. **The OHSU School of Dentistry Clinics (other than Russell Street Clinic) do not offer payment plans, a “sliding fee scale”, or financial assistance** (the financial assistance program at the OHSU Hospital does not apply here). A sliding fee scale is available for eligible patients at the Russell Street Clinic.

PAYMENT INFORMATION

- We accept, cash, checks and select credit cards for payment. There is a \$35 charge for checks returned for insufficient funds.
- Payment should be made in advance or at the time of service for all treatment provided. If treatment is not paid for by the date of service and/or is billed to the patient afterwards, payment is due within 30 days of receiving notification.
- Major types of treatment that require multiple appointments, such as Crowns, Bridges, Implants, Partial Dentures or Complete Dentures must be paid for in full prior to the start of the procedure.

OVERDUE ACCOUNTS AND COLLECTIONS

- Payment is due within 30 days from the billing date. Patients cannot receive treatment if their balance is more than 30 days past due.
- Accounts 60 days past due will be charged a \$25 late fee and will be notified that they are pending collections. Accounts 90 days past due will be charged a \$75 collection fee and turned over to a collection agency.
- Patients who are sent to collections will be discontinued from continued care. To resume treatment the patient must pay the balance in full and make an appointment through the Admitting Clinic. More than one instance of collections in the patient’s record may prevent re-acceptance into our program.

INSURANCE

- It is the patient’s responsibility to let us know if they have dental insurance and to notify us of any changes in insurance coverage. An additional insurance consent form must be signed before insurance can be billed.
- The patient is financially responsible for the entire cost of treatment, regardless of insurance coverage. It is the patient’s responsibility to know their benefits and to communicate with their insurance company if there are questions or disputes.
- Most insurance companies pay within 30-60 days. **If insurance has not paid their estimated benefit in 90 days, the ‘insurance portion’ of the balance will be billed to the patient and is due within 30 days of notification.**
- **We will not allow the patient account balance to remain overdue while he/she is working to resolve insurance disputes.** If a patient is billed for the estimated ‘insurance portion,’ payment is due within 30 days of notification.
- If insurance pays a benefit after a patient has paid the balance in full, we will either credit the patient’s account or work with the insurance company to pay the member directly. Once treatment is complete or the patient leaves the program, we will issue a refund for any credit on the patient’s account. Due to OHSU processes, it may take up to 4-6 weeks to receive a refund in the mail.



Financial Policies Consent, continued

FINANCIAL AGREEMENT: If I have health insurance, I understand that the terms of my health insurance or health benefit plan(s) may reduce, limit or control what I am required to pay OHSU for the services I receive at OHSU. Whether or not I have health insurance, I agree to be financially responsible and pay for the services provided to me by OHSU if the services are not covered or fully paid for by Insurance and the law allows OHSU to collect from me the amount owing. I also agree to pay OHSU's reasonable costs for collecting payments if I do not pay on time the amounts I am responsible for paying. These collection costs may include reasonable attorney fees whether or not legal action has been filed or appealed.

ASSIGNMENT: I assign to OHSU and/or OHSU Medical Group the right to receive benefit payments directly from my health insurance or health plan for reimbursement of the hospital, physicians and other services I receive at OHSU. I understand this assignment is final.

I authorize my health insurance and health plans to make payments directly to OHSU. OHSU Hospital, Faculty Practice Plan, Faculty Dental Practice, or other related professional billing services. I understand the payments from my health insurance or plan for services provided to me at OHSU will be applied to my patient account balance and total financial responsibility. I agree to pay within 30 days following OHSU's notification any charges I owe which are not covered and paid by insurance(s).

SOCIAL SECURITY NUMBERS: I understand that OHSU collects administrative and nonmedical patient information including Social Security numbers to identify patients, comply with federal and state reporting requirements, bill insurance carriers, and collect payments, as authorized by ORS 351.070 and 353.050. I understand I do not have to give OHSU my Social Security number. If I provide this information, I authorize OHSU to use it for the purposes listed above.

CLAIMS: I understand that each person is responsible to be informed about laws that affect him or her. I also understand, however, that OHSU wishes to alert me to a limitation in the law that relates to OHSU: Because OHSU is a public body, Oregon law may limit the dollar amount that a person may recover from OHSU or its caregivers for a claim relating to care at OHSU, and the time within which a person may bring a claim. If I have any questions about this, I understand that I am free to ask or seek advice from any independent person or source.

TELEPHONE COMMUNICATION: By signing this document, I expressly give OHSU, its affiliates, agents, and contractors consent to contact me using an auto dialer, prerecorded message, live operator, or other means at any telephone number or any contact information for any other communication device that I provide for treatment, payment, or other health care operations purposes, as those terms are defined in 45 CFR 164.501, as long as such contact complies with applicable law.

By signing below:

I acknowledge that I have read and understood the SOD Financial Policies.

I understand that I may request and be provided a copy of these forms.

I agree to abide with the rules and regulations of the School of Dentistry.

Patient Name: _____

Chart: _____

Signature of Patient (If Applicable): _____

Date: _____

I am not the patient, however I am accepting financial responsibility for this patient's treatments. I have read the Financial Policies and agree to abide by the rules and regulations of the School of Dentistry.

Guarantor Name: _____

DOB: _____

Address: _____

Phone: _____

Signature of Guarantor: _____

Date: _____