3818 SW 21ST Place, Suite 100, Redmond, OR 97756 (O) 541-548-2899 (F) 541-504-3787

General Policies

- I understand that Your Care does not treat or manage chronic pain.
- I understand that Your Care does not treat migraine headaches with narcotics.
- I understand that Your Care is not a designated primary care clinic, however we can address some primary care issues on a limited basis.
- I understand that if I am covered by the Oregon Health Plan, by contract, Your Care cannot do any primary care. We may in some cases be able to process some referrals.
- I understand that if I am being treated for Workers' Compensation Claim, any changes in my treatment plan and/or prescription require an appointment.

Financial Policies

- I understand that if I am being treated for a motor vehicle accident injury, Your Care depending on the circumstances of the accident may collect a deposit or payment in full at the time of service. We will as a courtesy bill your insurance carrier if you provide us with complete and accurate information. We will not hold charges pending in litigation. If your insurance carrier denies, or reduces fees, the balance becomes your responsibility.
- I understand that if I am being treated for an injury sustained at work, I will need to provide the date of injury, claim number if known, employer's complete name, address and phone number. You will be asked to fill out forms required by the State. This office will bill the insurance carrier, however, if you claim is denied we will bill your private health insurance. If you do not have private health insurance you will be responsible for payment in full.
- I understand that Your Care will verify insurance coverage including deductible and copay and/or co-insurance amounts. Your Care will collect required payment when I check in and any further balance due regardless of insurance coverage upon check out.
- I understand that I may receive a statement for services that were not covered in full by my insurance company. All balances are due within 30 days. If for any reason you cannot pay your balance in full, you will need to contact our billing office and make payment arrangements.
- I understand that outside services, such as lab work and imaging, may be referred and that I may receive a bill from providers outside of Your Care.

By signing below, I agree that I have reviewed and understand the Your Care's General and Financial Policies

Please Print: Last Name:_____ First Name:_____

_____ _____

DATE SIGNATURE OF PATIENT OR PERSON AUTHORIZED BY LAW