Date: _____ Birthdate: _____

Patient Name: _____

Sherman County Medical Clinic
Reception: 541-565-3325
Billing: 541-565-0536
110 Main Street
Moro, OR 97039

SHERMAN COUNTY MEDICAL CLINIC

# SCMC Financial Policies

Thank you for choosing Sherman County Medical Clinic (SCMC) for your healthcare services.

Please review the policies below carefully and feel free to ask questions should you have them. In order to ensure accurate billing and prevent fraud, we ask each patient to provide us a copy of a photo ID along with their insurance card. When you receive a new insurance card or change to another health plan, it is your responsibility to inform us with updated policy info and provide us with a copy of the card.

We will bill your insurance as a courtesy and must have accurate health plan information. This includes primary and secondary, automobile and workers' compensation insurances. Failure to provide us with accurate and up-to-date information specific to your visit will result in patient responsibility for the balance owed.

In is the patient's responsibility to check with their health plan for eligibility and benefit details including: 1) In-network provider status; 2) Primary Care Provider (PCP) assignment, and 3) potential financial responsibility for services not covered on or after the date of service at SCMC. **By signing below, I accept this responsibility.**

Most office visits require a co-pay which is due at the time of service. If your co-pay is not printed on your card and/or we are unable to view when checking eligibility, a standard co-pay of $25 will apply. A percent co-pay or co-insurance fee will be converted to a set amount per SCMC. A charge of $3.95 will be added for estimated copay/coinsurance.

If you don't have health insurance, have a high deductible plan or your account is in collections status, we require a 70.00 deposit every visit. If you have no health insurance due to low/no income, please inquire about our sliding fee scale.

There is a $30 charge on returned checks. Failure to pay your bill or to make arrangements with our billing department could result in a dismissal from the practice and your account being assigned to an outside collection agency where you will be responsible for all collection cost and attorney fees incurred.

After three no-shows to a scheduled appointment, you will be dismissed as a patient from our practice.
As of January 01, 2021, there will be a $25.00 fee charged for No Show Appointments or Failure to give 24 hour notice of an appointment cancellation.

**I understand and agree to Sherman County Medical Clinic financial policies as described above.**

Signed_____ by _____
(mm/dd/yyyy) Signature of patient

Signed_____by_____
(mm/dd/yyyy) Signature of parent, guardian, or legal representative