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Southern Oregon Cardiology LLC  
AUTHORIZATION FOR RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby assign all medical and/or surgical benefits to which I am entitled, including Medicare, to be paid to Southern Oregon Cardiology LLC. I authorize the sending of any and all medical information needed to secure payment. Copies of these records can be mailed, faxed or transmitted electronically via secure sites. This assignment will remain in effect until revoked in writing. I further permit a copy of this authorization to be used in place of the original.

I fully understand that I am financially responsible for any and all amounts not otherwise paid by my insurance carrier. (**This includes annual deductible, co-payments and charges denied as not covered by my insurance program.**) Account balances are to be paid in full within 30 days of receiving a statement. I understand accounts become delinquent 90 days following date of service and these charges may be assigned to a collection agency.

**Insured Patients:** Billing your insurance is a courtesy we are happy to provide for you. If the insurance does not respond you will become responsible. All co-pays and deductibles are due in full at time of service. If you are unable to pay your deductible in full you will need to meet with the billing department to set up a payment plan. If no insurance card is presented upon arrival you will be considered self-pay.

**Uninsured Patients:** A 15% discount will be offered to you if you pay in full at time of service. Prior to your appointment arrangements for payment will need to be established.

**Authorizations:** Please call your insurance to obtain insurance requirements for your visit or testing. Failure to obtain necessary pre-authorization or notification may result in a reduction or rejection of benefits by the insurance company.

**Missed appointment fee:** If you miss your appointment, or you cancel with less than 24 hours notice, there will be a \$25.00 missed appointment fee charged. Please call us 24 hours prior to your appointment to cancel or reschedule.

**Returned Check:** There is a fee (currently \$25.00) for any checks returned by the bank

Confidential information expressly identifies the medical nature of the services rendered. It includes all information and records obtained in the course of treatment. I authorize Southern Oregon Cardiology LLC to send copies of my records to my referring physician, PCP or other medical care providers for treatment purposes. Copies of these records can be mailed, faxed or transmitted electronically via secure sites.

**I HAVE READ AND UNDERSTAND THIS FINIANCIAL AGREEMENT. I HAVE HAD AN OPPORTUNITY TO ASK QUESTIONS AND HAVE RECEIVED A COPY. I ACCEPT THE RESPONSIBILITY OF ITS TERMS.**

Signature: \_\_\_\_\_ Date signed: \_\_\_\_\_

*If someone other than the patient is signing the authorization, please state relationship to patient and reason patient is unable to sign.*