12655 SW Center Street, Suite 150
Beaverton, Oregon 97005
Phone (503) 832-0945
Fax: (503) 430-8125

INSURANCE COVERAGE

We check health plan benefits as a courtesy to our patients. A quote of benefits does not guarantee payment or verify eligibility. We encourage you to verify your insurance coverage online or via telephone through the member services line for your insurance carrier.

Please be mindful that for most health plans, coverage begins once your deductible has been met each calendar year. Depending on your health plan benefits, each visit to the Center of Excellence in Co-Occurring Medicine will cost roughly $150.00 to $200.00 until your deductible has been satisfied. Once your bill has been submitted to your insurance carrier, your account will be adjusted according to the reimbursement rate.

BENEFICIARY AGREEMENT

I understand my health insurance carrier can deny services if they are not considered medically necessary. It is my responsibility to understand my coverage and benefits. I agree to be personally and fully responsible for any charges related to my health plan's deductible, co-insurance, co-payments or any other amount that the insurance deems patient responsibility,

_____ _____

PATIENT'S SIGNATURE **DATE**

WORKERS' COMPENSATION/AUTO ACCIDENT

I am fully aware that most workers' compensation and auto accident insurance carriers determine coverage once they have reviewed all supporting documentation. If at any point during my treatment or thereafter, my claim is not accepted and/or services were not covered, I can choose to have my private insurance billed. I have reviewed the above information pertaining to private insurance and understand any outstanding balance not covered by my WC/AA or private insurance is my responsibility.

Date of injury / accident: _____

State in which injury / accident occurred: _____

Insurance Company: _____ Claim #: _____

Adjuster Name: _____ Phone: (_____)_____

Patient's Signature: _____ Date: _____