Marian Wolfe Dixon, MA, LMT (OR Lic. #3902)
6901 SE 65th Avenue, Portland, OR. 97206
phone 503-232-7282

Policy Statement

Billing/Payment Agreement: By billing your insurance company for reimbursement of services provided by this office, you are being extended credit. There is no guarantee that your insurance carrier will cover all or any of the services provided even though your physician has prescribed it. Any portion of your bills not paid by the insurance company is your responsibility including no payments, late fees, no show charges, administrative fees and interest accrued.

All claims are due upon receipt. If your claim is not paid within 60 days of billing, then pursuant to ORS 742.524, the account is considered delinquent. This office may consider one or all of the following options in order to collect on your delinquent account. 1) the claim may be resubmitted to the insurance company or a complaint may be filed with the Oregon Insurance Division (once at no charge). 2) A monthly payment plan may be set up. Interest will accumulate at the current allowable rate. This is paid by YOU; any fees overpaid by the insurance company will be reimbursed to the one making the payments. 3) the delinquent account may be turned over to a credit/collection agency. They will pursue payment, which may include additional collection fees. This option may affect your credit rating.

Remember, ultimately you are responsible for the payment of your bill. Avoid extra charges by attending all scheduled appointments and being proactive with your health care and billing. You may wish to retain an attorney for personal injury and workers compensation cases.

Cancellation Policy: To avoid additional fees, arrive on time for your scheduled appointment or give notice by 5 PM the night before when calling to cancel/reschedule a session. **These charges are billed directly to YOU, the Patient.**

Late fee ($25) = fee for arriving 15 or more minutes late for your appointment.
No Show Fee (cost of appointment made but not cancelled) = fee for an appointment scheduled but skipped or canceled without notice by 5 PM the night before the scheduled appointment. (Fee subject to change.)

Assignment of Benefits: I authorize payment of my insurance benefits for services rendered by this office to be paid directly to Marian Wolfe Dixon.

Release of Records: I authorize Marian Wolfe Dixon, MA, LMT to release any information regarding my treatment of requested by my insurance carrier or designated attorney to process, administer, and pay outstanding debts for medically necessary services.

I agree that I have reviewed and understand the information on this Policy Statement. I also understand that I may request a copy of any or all of my medical records for a reasonable or allowable fee.

Name (print) _____

Signature_____Date _____