OB/GYN CENTRE OF EXCELLENCE
FINANCIAL POLICY

We are committed to providing you with the best possible care. If you have medical insurance, we are eager to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

Office Visits/Injections

Co-payment, coinsurance, and/or deductible for services rendered are due at the time of service. We accept cash, checks, debit cards, American Express, Discover, MasterCard, and Visa.

We will file a claim with your insurance company based upon services rendered. You will be responsible for quoted patient liability based on the explanation of benefits your insurance companies provides or any non-payments by your insurance company. If your patient liability is greater than the amount paid at time of service, you will be responsible to make additional arrangements to pay the remaining balance.

OB Services

Upon notification of OB services, we will contact your insurance company to obtain an ***estimate*** of your benefits. Based on the benefits provided from your insurance company, you must pay the estimated coinsurance in full or set-up no interest payments by the end of your first trimester. If your patient responsibility is greater than estimated, you will be responsible to make additional arrangements to pay the remaining balance.

Surgical Procedures

When a surgical procedure is scheduled, benefits are obtained to determine patient responsibility. Payment is required at this time. You may arrange to pay with a credit card, automatic drafts, or place a deposit of $500. If your patient responsibility is greater than estimated, you will be responsible to make additional arrangements to pay the remaining balance.

Self-Pay (No Insurance)

Payment for services rendered is due at the time of your appointment. If exact benefits are unavailable, a $75 deposit is required.

Divorce

In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Returned Checks and Non-Payment Fees

Returned checks are subject to an additional fee of $25. Accounts submitted to a collection agency are subject to additional collection fees of 30% and/or attorney fees. You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Insurance

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize, however, that:

1. Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.
2. Our fees are generally considered to fall within the acceptable range by most companies; therefore, are covered up to the maximum allowance determined by each carrier. This applies only to companies that pay a percentage (such as 50% or 80%) of "U.C.R.". "U.C.R." is defined as usual, customary, and reasonable.

3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
4. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or authorization may result in a lower payment from the insurance company.

If you have any questions about the above information or any uncertainty regarding your insurance coverage, PLEASE do not hesitate to ask us. We are here to help you.

The Patient (Guardian) agrees to be fully responsible for the total payment of procedures performed in this office including any amounts which are not covered by any insurance or other payment program. We allow 90 days for the payment of insurance coverage; thereafter, it is the patient's responsibility of payment. In the process of reviewing this information, we may find it necessary to obtain a copy of your credit through a credit reporting agency. Once I have signed this agreement, I agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

Patient's Name: _____ Responsible Party (if not patient): _____

Signature of Patient or Legal Guardian: _____

Date of Signature: _____