CIRCUMCISION DEPOSIT POLICY

As the billing provider, we have a specific time frame in which we must bill services to your insurance company. If you have a baby boy and you have chosen to have this service performed it is your responsibility for getting us his insurance information within 30 days of birth. So, to not cause any confusion or miss timely filing we have implemented this policy in our office. Once we have received payment from your insurance carrier you may be due a refund in the amount you paid in full or a portion of that amount. **We reserve the right to use this refund for any outstanding balances due on your accounts here at Capital OB/GYN.**

The refundable deposit amount you are responsible for is: $236.00

We require that the payment of our circumcision service be paid in full by your 28th week/beginning of your 3rd trimester of pregnancy. If you need us to tell you when this is we are happy to do so. We are fully aware that your child/dependant cannot be added to your insurance policy until the time of birth. We ask that you contact our office as soon as possible with your child's insurance information and then bring a copy of the card into our office at your Post Partum appointment.

We accept Cash, Check, Master Card, Discover and Visa. If you have any questions about your circumcision benefits, please feel free to contact your insurance company.

We believe that good care for you and your family starts with good communication, and we have created this policy to help our patients understand the responsibilities that they and their families have for payment of our fees. If at any time you have questions or concerns with our fees or payment process, please do not hesitate to talk to our office manager Beverly at 512-836-2536.

Thank You, Financial Department of Capital Ob/Gyn Associates of Texas

I have read and understand the circumcision deposit policy and I agree to terms by my signature below. I also understand and agree that such terms may be amended by the practice at any time.

Patients Name _____ DOB _____

Acct# _____

Patients Signature _____ Date_____