FINANCIAL POLICY

As we enter this doctor-patient relationship, we agree to provide quality healthcare care at a fair and reasonable price, and you in turn, agree it is your obligation to be prepared to pay at the time of service and to understand the benefits of your insurance. We want to explain our financial policy to you so there are no unpleasant surprises.

- **Co-payments, deductibles and/or coinsurance are due at the time of service.** We accept Cash, Personal Check, MasterCard, Visa, and Discover. If you are not prepared to pay the required amount, we are required to reschedule the appointment. The estimated financial responsibility for scheduled services will be due ***prior*** to these services being provided. Any remaining balance after your health plan pays will be due upon receipt of a statement. If insurance coverage cannot be verified prior to the appointment, the account will be notated as private pay and payment will be due in full. *Account balances over 90 days with no payment activity will be reported to the credit bureau(s).* ***Initial*** _____

- **Your insurance policy is a contract between you and your insurer. It is your responsibility to know what your policy covers and what it does not although we will help you get the most out of your benefits.** We cannot quote your benefits. Any item deemed "non-covered" by your insurance carrier will be your financial responsibility. We do not accept 'usual and customary' payments. Any disputes about payment must be resolved between you and your insurer. This also includes lab designation and payment disputes. You are responsible for ensuring a properly dated referral and/or authorization if required by your insurer for services being provided. It is your responsibility to make certain you have subsequent authorizations during ongoing treatment. You are also responsible for payment if your claim denies for lack of referral/authorization.
  Initial _____

- As a courtesy to you, we will file primary participating insurance for you with proper assignment within 3 business days of your appointment. Insurance will not be accepted if presented after 3 business days from the date of your appointment. Any additional policies will be yours to file with your receipt from our office. Please bring your primary insurance card with you to <u>every</u> visit and provide the front desk with any updated information at check-in. I understand that all remaining balances are my responsibility to satisfy prior to additional services being rendered. ***Initial*** _____

- This office is not party to legal disputes or agreements. The financial responsibility rests with the patient. ***Initial*** _____

- A $35.00 processing fee will be assessed for all returned/NSF checks. ***Initial*** _____

- A $15.00 completion fee is collected for *FMLA/Disability forms*. This fee is charged per pregnancy, per incident and collected at the time you request completion. Insurance Companies will not pay these fees. ***Initial*** _____

- We reserve the right to charge a $30.00 *NO SHOW Fee* for appointments that are *not cancelled within 24 hours* of the appointment. ***Initial*** _____

- Payments & credits are applied to the oldest charges first, except for insurance payments, which are applied to the corresponding dates of service. ***Initial*** _____

ASSIGNMENT OF BENEFITS

I request payment of the medical benefits, otherwise payable to me, directly to *Capital ObGyn Associates of Texas, PA* for services provided by them.

I have read and understand the practice's financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice at any time.

_____ _____

Responsible Party, ***Printed Name*** (Must be 18 or over) Date

_____ _____

Responsible Party, ***Signature*** (Must be 18 or over) Date