Financial Policy

Thank you for choosing Advanced OBGYN as your health care provider. The following is a statement of our Financial Policy. Please read the policy carefully. We require that you sign the policy prior to receiving treatment. The signed copy will be retained in your patient file.

1. We ask that you present your insurance card(s) at each visit. It is your responsibility to provide us with complete and correct information to ensure proper billing to your insurance company(ies).

2. If you have a change of address, telephone numbers, or employer, please notify our office as soon as possible.

3. We will collect your deductible, co-pay, co-insurance, or charges for non-covered services at the time of your visit. If you have a balance after an insurance payment from a previous visit, we will also ask for that payment. We accept cash, check (with proper ID), money orders, Visa, and MasterCard. THERE IS A $35.00 CHARGE FOR ALL RETURNED CHECKS.

4. If we do not participate with your insurance provider, we will file your claim(s) as a courtesy; however, you will be expected to pay for your services at the time of your visit.

5. Please be aware that a portion or all of services provided to you may not be covered services or may not be considered reasonable and necessary by your insurance company. By signing this form, you acknowledge responsibility for payment regardless of any insurance company's determination of usual and customary rates.

6. If your insurance company denies our charges or does not pay us in a timely manner, you will be billed for the entire balance. You will be expected to pay your balance in full within 30 days or call our billing department to make payment arrangements. If payment is not received in a timely manner, your account may be referred to an outside agency for collection assistance. You have the option to keep a credit card on file with our office to facilitate the payment of your balance. Please refer to the end of this policy for more information.

7. Regardless of the source of payment for care provided, you have the right to request and receive itemized and detailed explanations of any billed services.

8. **MEDICARE PATIENTS**: Advanced OBGYN is a participating provider with Medicare Part B. We will bill Medicare for all of your covered charges. If you have a supplemental carrier, we will also bill that carrier for you. If payment is not received from your supplemental carrier within 45 days of being submitted, we will bill you for the balance due. IF YOU DO NOT HAVE A SUPPLEMENTAL CARRIER, THE PORTION NOT COVERED BY MEDICARE (20%) WILL BE COLLECTED AT THE TIME OF YOUR VISIT. Each year you will be expected to pay the allowed amount of your charges until your annual Medicare deductible has been met.

9. **MANAGED CARE (HMO, PPO) PATIENTS**: If we participate with your plan, we will bill your insurance for you; however, your co-pay WILL BE COLLECTED IN ADVANCE OF TREATMENT, NO EXCEPTIONS. If your plan requires you to choose a primary care physician (PCP), it is your responsibility to make sure your insurance company has your PCP on file. Our

office will contact you if we determine that you will need to make a payment other than a co-pay prior to receiving services.

10. **SELF-PAY PATIENTS**: Patients without medical insurance coverage must pay for requested services prior to receiving treatment. We will provide information on the cost to you for the services we reasonably expect you to receive. If you will not be able to pay in full, you must contact our billing department to make payment arrangements.

Again, thank you for choosing Advanced OBGYN as your health care provider. We will help you in any way that we can with billing and insurance issues, but ultimately YOU are financially responsible for payment for the services you receive. If you have any questions regarding our Financial Policy or any other billing matter, please contact our billing department.

_____ _____
Signature of Patient/Legal Representative Date

_____ _____
Patient Name (Please print name) Patient Date of Birth

AUTHORIZATION FOR CREDIT CARD CHARGES

You have the option to keep a credit card on file with our office to facilitate the payment of your balance. By signing this form and providing your credit card information, you acknowledge that Advanced OBGYN has the authority, at your direction, to charge your credit card for services not covered by your insurance plan or for services not covered because your deductible has not been met.

_____ _____
Signature of Patient/Responsible Party Date

_____ _____
Credit Card Number Type Expiration Date