



FINANCIAL POLICY

Thank you for choosing our practice. Our office is committed to providing the best possible treatment and also in assisting you with insurance filing and payment of your account. In order to accomplish this in a cost effective manner, we ask that you adhere to the guidelines listed below.

1. We will file a claim to your insurance carrier if we are given complete demographic and insurance information. If information is incomplete, we will require payment in full of your charges the day of your visit.
2. Co-payments are due at the time of service. A \$10.00 service fee will be assessed for failure to pay a co-payment when you checkout.
3. Since we are unaware of each insurance plans specific benefits and which of our services are covered by your plan, we will not be held responsible for unpaid amounts as a result of denials from your insurance company due to non-covered service clauses.
4. Most laboratory charges ordered through our office are billed separately to your insurance by either Lab Corp, Quest Diagnostics, or Phyttest, our lab billing service. If you receive a bill from one of these companies, we ask that you contact them to resolve any question you may have.
5. We realize that OB patient's insurance plans may change over the course of the pregnancy term. We require that the patient keep us updated on those changes. Failure to provide updated information in an expedient manner may result in timeliness denials from your insurance carrier which the patient will ultimately be held responsible for.
6. All OB patients are required to pay at least 50% of the portion of the delivery fee not covered by insurance by the 1st day of the 4th month of pregnancy. The remaining 50% is due by the 1st day of the 6th month. OB patients are also required to promptly pay for any other services provided during the pregnancy. Care may be discontinued at any time for noncompliance of the above.
7. Account balances that have not been paid within 60 days will be charged a finance charge of \$3.00 or interest of 1¹/₂% per month (whichever is greater).
8. We expect you to call at least 24 hours in advance in the event you cannot make an appointment. A \$25.00 fee will be assessed for all no shows.

I have read and received a copy of the Payment Policy. I accept this policy for treatment with OB-GYN Associates.

Patient Name _____ Signature _____

Date _____