OB/GYN SPECIALISTS
FINANCIAL POLICY

Thank you for choosing an OB/GYN Specialists Physician as your healthcare provider. We are committed to your treatment being successful. The following is a statement of our Financial Policy, which we require you read and sign annually.

1. <u>All co-payments and deductibles are due at time of service. Full payment is due at time of service for all non-covered services. Our contract with your insurance company requires us to collect these from you.</u>

2. It is your responsibility to provide OB/GYN Specialists, LLP with accurate demographic and insurance coverage information. OB/GYN Specialists, LLP will be unable to accept your insurance if sufficient proof of insurance and/or identity cannot be verified. If OB/GYN Specialists, LLP is unable to obtain accurate and complete information and therefore unable to bill your insurance company, OB/GYN Specialists, LLP will bill you for <u>PAYMENT IN FULL.</u>

3. For your convenience OB/GYN Specialists, LLP will submit a claim to your insurance company on your behalf. You agree to assign and authorize OB/GYN Specialists, LLP to bill, collect and/or negotiate payment by the insurance plan on behalf of your insurance benefits in place at time services are rendered.

4. If you are having a surgical procedure applicable deductibles, co-pays, or coinsurance for surgical procedures shall be collected prior to surgery. Estimates of the amounts will be provided.

5. Your insurance plan may not cover all services and/or supplies provided to you during your treatment with OB/GYN Specialists, LLP. In the event your health plan determines a service to be “non-covered”, you will be responsible for total charges at time of visit or upon receipt of a statement from OB/GYN Specialists, LLP.

6. It is important for you to respond to your insurance company when <u>any</u> information is requested from you. Some insurance companies require this with your first claim each calendar year. **When your insurance company notifies us they have requested information from you, the balance then becomes your responsibility and remains your responsibility until the claim is paid.**

7. Other than your first statement for services rendered, OB/GYN Specialists, LLP charges a fee of $3.00 per statement mailed. To avoid being assessed this fee we offer Autopay. Payment information may be provided to the billing office for an agreed amount to be applied monthly to your account. If monthly payments are not received regularly, your account will automatically move into our collection process.

8. If your insurance plan denies or delays payment to OB/GYN Specialists, LLP within a reasonable period according to State of Georgia Prompt Payment rules, you will be responsible for payment in full. Should it be necessary to refer the account to a collection agency for collection, you will pay reasonable collection expenses including but not limited to attorney fees and court costs.

9. Procedures such as surgery often result in charges other than those from OB/GYN Specialists, LLP. These include surgery center or hospital costs, anesthesia costs, etc.

10. If you are a self-pay patient, we have a self-pay policy. Please see the billing office for assistance.

11. A No Show Fee of $50 may be charged for patients who do not cancel or reschedule their appointments prior to 24 hours before their scheduled appointment.

12. There will be $35 fee assessed for insufficient funds when paying by check.

13. There will be prepaid fee of $35 for completing individual medical forms, disability, work restriction, employer forms, school forms, etc. Five to seven working days is required to process all form requests.

14. **It is your responsibility to check with your insurance company prior to your appointment for verification of benefits such as preventive services, lab and x-ray procedures, etc. Many insurance plans now require you to go to <u>specific labs, x-ray facilities, pharmacies, etc.</u>**

Your signature certifies that you have read the foregoing and accept its terms. Further it acknowledges your responsibility regarding charges related to your care.

X____ X____________________________________

Patient or Patient’s Representative or Responsible Party Date

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