# FINANCIAL POLICY

Thank you for choosing us as your health care providers. We are committed to providing you with the best possible care. Your clear understanding of our financial policy is important to our professional relationship. **We ask that you carefully read and sign the following financial policy.**

**** We require a copy of all insurance cards and ask that you present them at each visit.**

**** All new patients must complete our patient information forms AND our EMR (Digi Chart) before services are rendered.**

**** It is your responsibility to inform the practice of ANY or ALL pre-existing health conditions. Failure to do so may result in a denial from your insurance company. If this happens YOU are responsible for any outstanding balance.**

**** The forms of payment we accept are: Cash, Check, Visa, MasterCard and Discover.**

**Participating Insurances:** We participate with most insurance companies. Co-pays and/or deductibles are due at the time of service.

**Non-Participating Insurances:** Payment in full is required at the time of service.

**For All Insurances:** Please review your benefit listings summary. Well Woman or Annual Exams are usually considered as preventative care. This is often not covered by many insurance plans.

**For Medicare:** There is coverage for breast, pelvic exam and Pap smear – based on certain criteria. However, Medicare may not cover all of the Well Woman preventative exam.

**Obstetrical Patients:** After your visit to confirm your pregnancy, you will receive a letter along with financial information from our office detailing your insurance coverage and benefits to determine your financial obligation to us for your pregnancy care.

**Cancellation Policy:** If you must cancel or reschedule your appointment we would appreciate at least a 24 hour notice or you will be subjected to a $25 fee if proper notice is not given for cancelled or "no show" visits.

**Returned Checks:** There is a $30 fee on all returned checks.

I understand and agree that health insurance coverage is an agreement between an insurance carrier and me. I understand that this office will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amounts authorized be paid directly to this office. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I authorize OB-GYN Associates of Oak Ridge, P.C.to furnish information to insurance carriers concerning my illness and treatments. If delinquent account is turned over to our collection agency the patient is responsible for all associated collection fees, court cost, etc.

In the event that the patient is a minor, I am the parent and/or legal guardian of said patient and agree that I am responsible for all services rendered to the patient herein.

| _____ | _____ | _____ |
|---|---|---|
| Patient's Signature | Patient's printed name | Date |
| _____ | _____ | _____ |
| Parent/ Guardian Signature | Parent/ Guardian Name | Patient name if Minor |