

# Wooster OB-GYN Financial Policy

**Please complete and mail or take this form to the office at the time of your first visit.**

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. The following is a statement of our Financial Policy which we require you to read and sign prior to any treatment.

FULL PAYMENT IS DUE AT THE TIME OF SERVICES UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE. WE ACCEPT CASH, CHECKS, VISA/MASTER CARD and DISCOVER.

## **Regarding Insurance**

We will accept assignment of insurance benefits. Assignment simply means that we will bill your insurance and after receiving payment from them, bill you for the balance. We participate with a large number of insurance plans but it is your responsibility to check with your insurance company to be sure that we are on their list of providers. If you choose to come to our practice and we are not on your insurance company's panel, you will be responsible for the difference between what the insurance company pays and our charges. Your insurance company has the current list of participating physicians.

Payment of your co-payment is to be paid at the time of service. Failure to pay your co-payment will result in a rebilling fee of \$5.00. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give your correct insurance information. We reserve the right to see your insurance card with every visit. If you present an expired card or inaccurate information, you will be responsible for the total amount of the charges.

Your insurance policy is a contract between you and your insurance company. If your insurance company has not paid your account in full within 60 days, the balance will automatically be transferred to your account balance. Please be aware that some, perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurance. You will receive a statement each month even though an insurance claim is pending.

Do you have Medicare coverage? Yes No - If yes, is it Primary? Yes No (circle one)

## **Usual and Customary Rates**

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our specialty. You are responsible for payment regardless of your insurance company's determination of usual and customary rates.

## **Adult Patients**

Adult patients are responsible for full payment at time of services, unless other arrangements have been made prior to visit.

## **Minor Patients**

The adult accompanying a minor and the parents (or guardian of the minor) are responsible for full payment. For unaccompanied minor, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, Visa, Master Card, payment by cash or check at the time of service.

**Missed Appointments**

Unless canceled at least 24 hours in advance, our policy is to charge for missed appointments. The fee for a missed appointment is \$25.00. This cannot be billed to your insurance and is your personal responsibility. This amount must be paid prior to rescheduling another appointment. Please help us serve you better by keeping scheduled appointments.

**Self Pay Patients**

All patients are expected to pay for services at the time that they are received. However, some medical procedures are expensive and unexpected and as such may require time for payment. Payment over time is not permitted unless specifically authorized by a member of the business office staff. Self pay patients who have no balance on their account will be given a same-day discount for all payments made the date of service. Patients failing to pay at the time of service will not be eligible for prompt payment discounts.

**Bankruptcy**

If this office has been included in your bankruptcy, you will no longer be a patient with the practice.

**Termination**

If your account has been turned over to a collection agency for collection, you will be sent a letter terminating our services to you and/or your family from this office.

You will be given a 30 day period of time to establish with a new doctor. During those 30 days you can be seen by the doctor for emergencies only.

Thank you for understanding our Financial policy. Please let us know if you have any questions or concerns.

I understand that the responsibility for payment for Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I understand and agree to this Financial Policy.

X \_\_\_\_\_ Date \_\_\_\_\_  
Signature of Responsible Party

X \_\_\_\_\_ Date \_\_\_\_\_  
Signature of Co-Responsible Party