Sweetwater Ob/Gyn Associates

Office Financial Policy

Thank you for choosing us as your healthcare provider. We are committed to providing you with the best possible medical care at the lowest possible cost. In order to keep our fees to minimum we ***require*** that you pay at the time of service so that we do not have to send bills. We may order laboratory tests, perform office procedures or diagnostic tests as part of our comprehensive evaluation. Payment for these services are due and payable at the time of service. In order to achieve the clinic goals of providing the finest medical care at the lowest cost, we need your assistance and understanding of our payment policy.

Self-Pay
FULL PAYMENT FOR PROFESSIONAL SERVICES DUE AT THE TIME OF SERVICE.
We accept cash, checks, debit/ATM cards, Visa, MasterCard, Discover

Insurance
PAYMENT OF CO-PAYS AND DEDUCTIBLES ARE DUE AT THE TIME OF SERVICE. Service may be denied if payment is not made at check-in time. Our office will file an insurance claim for services rendered, but ultimately you are responsible for the bill. By law your insurance company must remit payment or deny your insurance claim within 30 days of initial notice. If your insurance company has not paid your account in full within 45 days we may ask for your assistance in getting your insurance company to pay the balance or the balance may be billed to you. We will file claims to your insurance company but your insurance policy is a contract between you and your insurance company. We are not a party to that contract and so your balance will be due immediately.

Insurance Coverage Changes
In the event that your insurance coverage changes to a plan where we are not participating providers, you will be responsible for payment of all fees at the time service is rendered. We will file insurance claims immediately for all these services, if requested, and reimbursement from the insurance carrier should be made directly to you. Again, if payments received by the office, a check will be issued to you within 30 days for reimbursement. We ask that you participate in any disputes with your insurance carrier regarding your policy guidelines and insurance payments.

Financial Responsibility for Minors
Unless prior arrangements have been made, charges for minor child seen in the office will be the responsibility of the adult accompanying the minor child.

Returned Checks
Returned checks are subject to a **$40.00 charge**, returned checks older than 30 days may be subject to an additional **$50.00** charge. Returned checks may be referred to the District Attorney for legal action in some cases.

Medical Records Request
There will be a **$25.00 charge** for every medical records request. Please allow 7 days to process copies of medical records.

Disability and/or Family Medical Leave Act (FMLA) Forms
There will be a **$25.00 charge** for completion of all Disability and/or FMLA forms.

No Show Policy
OB/GYN office reserves the right to charge a **$25.00 fee** for **NO SHOW** appointments. To avoid this fee, call our office to reschedule or cancel your appointment at least 24 hours before your scheduled appointment. This fee is NOT billable to your insurance company and will be your responsibility.

After Hours Calls
Your physician is on call after-hours and on weekends for serious medical problems or for medical emergencies. For routine medical questions or minor problems, please call during regular business hours. A **charge of $25.00** will be added to your account for any non-emergency calls.

As we stated above, the primary goal of our practice is to provide the finest medical care and services to the people in our community. Since our practice also has financial obligations which must be met, we ask that all patients pay for their examination and treatment in full on the day of each visit to our office. In regards to insurance plans where we are a participating provider, all co-pays and deductibles are due prior to treatment.

I have read, understand and agree to abide by the financial policy set forth.

I also acknowledge that I have received a copy of the *Sweetwater Ob/Gyn Associates • Notice of Privacy Practice*

_____ (please initial)

_____ _____

Signature of Patient/Responsible Party Date