OB GYN CARE GROUP

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Patient Responsibility and Your Insurance

PATIENT NAME: _____ DOB: _____ DATE: _____

Awareness of our office policies ensures we have the best patient relationship. Please initial each of the following:

_____ **PAYMENT METHODS.** We accept and encourage our Patients to use cash or personal checks as a form of payment. If you must use a credit card, we charge a convenience fee of 2.5% of your balance.

____ **NO SHOW / RESCHEDULED APPOINTMENTS**. Patients are required to give us one business day (24 hours that do not include weekends) to reschedule or cancel an appointment. There is a $25.00 NO SHOW fee charged to patients that fail to give us sufficient notice. For an ultrasound appointment the NO SHOW FEE is $50.00. Patients should know that we still have to pay the technician that is here when a patient leaves a slot empty by missing an appointment and we could have been seeing other patients. We truly value our patients and do our best to be considerate of your time. We need you to do the same.

_____ **LATE ARRIVAL FOR APPOINTMENTS.** Please call our office as soon as possible if you are going to be late for your appointment so that an appropriate solution can be developed. A patient 15 minutes late for her appointment will be considered a late arrival. We will do our best to accommodate by working you into the Provider's schedule, while trying not to delay the appointments of our other patients who were not late. If you are late you may be required to wait. If we are unable to work you into the Provider's schedule or you choose to reschedule the appointment, there will be $25.00 fee. All appointments that are canceled or rescheduled with less than 24 business hours notice will be charged a fee of $25.00.

_____ **STATEMENTS.** You are responsible for knowing you insurance information including deductibles, co-pays and co-insurance. Your co-pay amount is due on the date services are rendered. We encourage our patients to log into their insurance websites and call their insurance often with questions. We submit claims for services we render to your insurance. When we get the insurance response in many cases there is a "patient responsibility" due to deductible, co-insurance or co-pay. That patient balance is then sent to you in a statement. ***That balance is due when you get the statement to avoid late fees. We only send ONE statement***. If we have to send a second one it will be with a Ten Day Demand letter. ***Of course, we are here to help you.*** We WILL work with you but you MUST REACH OUT TO US. Call our Patient Advocate or Billing Department when you get your statement if you need an extension. Patients that are on a payment plan or our OB patients will get statements but no Ten Day Pre Demand letters because they already have arrangements. Any patient with an existing OUTSTANDING balance in default will not be seen until they pay the balance and may have to pay up front in the future. ***Make sure we have your correct address so statements will be mailed to the correct location.***

____ **GLOBAL FEE**. All OB patients are required to meet their financial responsibility by their 28th week of pregnancy.

____ **FORMS:** Please allow 3 to 5 business days for any forms such as (but not limited to) FMLA, Short term disability and/or insurance forms. There is a $25.00 fee to each form completed or signed by the practice.

____ **MEDICAL RECORDS:** If you request a copy of your medical records faxed to another Provider's office, we will send the records at no charge with a signed records release from the patient. All patients have access to their records through our patient portal. It is the policy of OBGYN Care Group that all balances on the patient account be paid in full prior to releasing medical records. If you would like a hard copy of your medical records for yourself or another provider, we will be happy to print your records with a signed medical records release and a hardcopy fee. The medical records hardcopy fee is: $1.00 per page for the first 20 pages and $0.25 per page thereafter.

____ **RETURN MAIL CHARGE**. Make sure we always have your current address because there is a $5.00 charge to patient's account for returned mail.

If you have any concerns about the financial aspects of your care here and or would like some help understanding your insurance ask to speak with a Patient Advocate or our Billing Department while you are here.