Financial Responsibility Agreement

This Patient Financial Responsibility Agreement will assist you in understanding your financial responsibility.

Responsibility. I understand I am responsible for all payment obligations arising out of my treatment and care and I guarantee payment for these services. At each visit, please be sure we have your current demographic and insurance information. It is your responsibility to provide us with this information, and update it if it changes. You will be responsible for any charges billed to the wrong insurance carrier as a result of not providing accurate insurance information. I understand I am responsible for any deductibles, co-payments, co-insurance or any other patient responsibility amounts indicated by my insurance carrier or for any services not covered by my insurance. We participate in most insurance plans, if your insurance is not a plan we participate in, you will be self-pay and payment plans are available.

Payments Accepted: I understand I can make payments by check, cash, debit cards or credit cards. ****There is a $35 fee for all returned checks****

Self-Pay Patients: Payment plans and or discounts are offered to our patients who do not have insurance. Please let us know if financial assistance is needed.

Annual Exams: Annual Exams cover a Comprehensive Medical History, Measurement of Height and Weight, Measurement of Blood Pressure, Performance of a Breast/Pelvic Exam, with a Pap smear (if applicable), and general Contraception inquiries/refills. It does NOT include: discussion or addressing of any new, pre-existing or recurrent gynecological problems. If any medical problems/concerns are addressed in the process of performing your Annual Exam and it requires additional time; ordering of tests, or diagnostic studies, it will be coded and billed as an additional non-Annual/Preventative visit and will require a copay or deductible at checkout. We are required to submit claims based on the services you receive.

I understand and agree it may be necessary to obtain tissue or perform lab tests to confirm a diagnosis or to determine a course of treatment. If any tissue is removed for a pathology examination or if a laboratory test (Pap smear, culture, etc.) is done in the office, the actual test is usually carried out by someone else. This means I MAY RECEIVE A SEPARATE BILL FROM a PATHOLOGIST OR LAB FOR THESE TESTS. It is necessary to contact that lab directly to resolve any billing concerns

Missed appointments & Cancellations: It is our goal to give you the best care possible. You can help us serve you better by keeping your scheduled appointments. I understand that I am required to provide at least 24 hours advance notice if unable to keep the scheduled appointment because the scheduled time slot has been reserved exclusively for me and/or my family members

Authorization to Contact: I authorize personnel to communicate with me by mail, answering machine messages, and/or e-mail according to the information provided in my patient registration information and my patient portal setting preferences. The office may use any information I have provided, including contact information, e-mail addresses, cell phone numbers, and landline numbers, to contact me for purposes related to my health and my account.

Forms: There is a flat $5 fee for completing each disability, FMLA, sick leave and AFLAC forms.

I, _____ (print name) have read the above patient financial policies and do solely agree to the above-named policies and acknowledge that these policies remain in effect for the entirety of my relationship with this clinic as a patient.

_____ Date: _____

Signature of patient or Parent/Guardian