

Please sign and date the bottom of the form that you have reviewed and understand all payment and insurance policies.

1. If my insurance claim denies payment due to incorrect personal information or incorrect insurance information that I have provided, I will be billed and payment in full will be due immediately.
2. If the services provided to you are not covered by your insurance plan, we will bill you for the full amount of the charge, which needs to be paid in full upon receipt of billing statement.
3. If I have insurance Printers Park OB/GYN, A Prof., LLC (Provider) **IS** contracted with, I authorize assignment of payment directly to Printers Park OB/GYN, A Prof., LLC for services provided to me.
4. Under the terms of the contract that I have with my insurance company, I **must** pay any predetermined co-payments at every visit they are due. Predetermined co-payments not paid at the time of service will have an additional \$25.00 billing statement processing fee added.
5. If I have insurance that the Provider is **NOT** contracted with, I agree to pay my bill in full at the time the services are rendered. Printers Park OB/GYN will file the claim for me if I think I might have coverage and I will be reimbursed the amount the insurance pays to the provider.
6. If my account or any account that I am responsible for is sent to a collection agency for non-payment, I will face possible dismissal from care, which includes all physicians at Printers Park OB/GYN, A Prof., LLC. If my account is sent to a collection agency for non-payment, a \$50.00 late payment fee may be added to the total balance.
7. It is **my responsibility** to know the services covered by my insurance and if my insurance does not cover these services, I will be responsible for payment.
8. It is **my responsibility** to check with my insurance plan to determine what facilities I can go to for services outside of this office and also what out-of-pocket expenses I might have associated with those services.
9. Most lab samples collected in this office will need to be sent to an outside lab for testing and those charges are separate from the charges incurred in this office, and are my responsibility. I understand that the Provider will forward the insurance information they have on file for me to the lab. The Provider will use the lab specified by my insurance to the best of their ability.
10. Printers Park OB/GYN, A Prof., LLC uses an Electronic Check Cashing system, which means my payment by check will usually be processed by my bank within 24 – 48 hours. If my payment by check is returned for insufficient funds I will be responsible for full payment the check is written for plus an additional \$25.00 returned check fee.
11. If the Provider must send me a billing statement for payment of services and I do not pay the balance within 30 days, I will be charged 1.5 % interest on the balance per month until it is paid in full.
12. I understand that if I do not provide my social security number and also for the person responsible for payment or insurance on the Patient Information Sheet, I will be required to pay cash for services regardless of insurance coverage.
13. If I am required to have a referral or authorization for office services, it is my responsibility to get one. I understand that if I do not get the required referral or authorization I must pay for services in full before the services are provided.
14. If I do not have **any** insurance and I am paying for my office visit, I will be given a 10% discount off the office visit. The discount only applies if I pay in full at the time of service. If my check does not clear the bank, the discount will no longer apply and in addition, I will be charged a returned check fee of \$25.00.
15. We must be able to copy a photo ID of the patient, or if a minor, patient’s parent or guardian. If this is not allowed, payment for services must be made by cash, money order, or credit card. A check for services will not be accepted.
16. If you are having an elective procedure done, we will collect any deductible, co-pay or coinsurance owed for that procedure before the procedure is done.
17. If you are pregnant and have insurance with a deductible, co-pays and/or coinsurance, those monies will be collected at each prenatal visit through our Pregnancy Installment Payment Plan. Please see our billing department for more explanation of this plan.
18. If you are on a payment plan, we now require the full balance to be paid within 90 days regardless of original terms unless you are pregnant. The balance must be paid by the 30th week of pregnancy on the Pregnancy Installment Plan.

*** For easier payment options, we offer a credit card payment plan. Please ask about this option.**

**** For any questions regarding these policies, please see our billing department or call (719) 634-1532, option 4.**

Patient or Legal Representative’s Signature: _____ Date: _____

Printed Name of Person Signing: _____

Printed Name of Patient: _____