By executing this agreement, you are agreeing to pay for all services received

Self-Pay Patients: All self-pay patients are required to pay at the time the services are rendered unless prior payment arrangements have been made.

Filing Claims: Please be sure you inform us of any updates or changes to your insurance so we have your current information. If we do not have current information this will delay payment and possibly cause you to have unexpected expenses. You will be asked to completely fill out a new information profile every year.

Insured Patients: If we are contracted with your insurance company we must follow our contract and its requirements. Your policy is a contract between you and your insurance company. We are NOT a party to this contract. We will bill your insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company who makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance. If you have a co-payment, co-insurance and/or deductible, you must pay at the time of service unless prior payment arrangements have been made. You agree to forward to **Comprehensive OB/GYN** all insurance or third party payments you receive for services rendered to you immediately upon receipt. If you disagree with the final processing of your claim and the amount due as indicated through the Explanation of Benefits from your insurance company you must inquire or appeal to them directly. This does not negate your financial responsibility to the balance owed unless your insurance plan reprocesses the claim and issues a corrected Explanation of Benefits and/or payment.

Insurance Verification: Our verification staff is dedicated to ensuring your visit is covered by your insurance or advising you otherwise prior to your appointment. In some instances we might not be able to obtain this information. It is necessary for you, as the patient and covered party, to check with your insurance carrier to verify your specific benefits to avoid financial surprises. All information obtained by our staff through your insurance company is always prefaced with the following statement "A quote of benefits and/or authorization does not guarantee payment or verify eligibility. Payment of benefits are subject to all terms, conditions, limitations, and exclusions of the member's contract at time of service." With this in mind we will do our due diligence to estimate your coverage and out of pocket expense however we are limited by the information given to us the potential for changes in your policy.

Referrals: If your plan requires you to choose a primary care physician it is your responsibility to make sure your insurance company has your selection on file. If your plan requires you to have an authorization to see a specialist, you will need to obtain that from your PCP and have it sent to us prior to your appointment. If we are listed as your PCP and an authorization is needed to see another specialist or for hospital admissions you will need to notify us 3 business days prior to the date of service in order for the request to be completed. We will not request retro-dated authorizations. Please do not attend an appointment requiring an authorization without prior clearance from us or your insurance company. If you aren't sure if an appointment requires an authorization please contact your insurance company.

Statements: Unless other arrangements are approved by us in writing the balance on your statement is due and payable when the statement is issued. It will separately show the previous balance, any new charges to the account and any payments or credits applied to your account during the month.

Returned Checks: There is a fee (currently $25.00) for any checks returned by the bank.

Past Due Account: Your account becomes past due 30 days following receipt of your first statement, we will take necessary steps to collect this debt. We have the option to report your account status to any credit reporting agency such as a credit bureau.

Waiver of Confidentiality: Please understand if this account is submitted to an attorney or collection agency, if we have to litigate in court or if you're past due status is reported to a credit reporting agency, the fact you received treatment at our office may become a matter of public record.

Appointments: It is our goal to provide services to you in the most comfortable and timely manner as possible. In order to achieve this we must require you to be on time for your appointments. If you must cancel an appointment we ask you give us 24 hours notice whenever possible. Patients who are 15 or more minutes late may not be seen at the scheduled appointment time however may be worked back into the schedule as available. Missed appointments without notification may be charged a $25 fee which will need to be paid prior to next appointment. If you miss three appointments without notifying us before the appointment time you may be dismissed from the practice. **Surgeries cancelled up to 7 days prior to the scheduled surgery date will be subject to a $300 non-refundable service fee**. In order to ensure accurate records and true identity of all patients you will need to present your Driver's License or Identification Card, Insurance Card and Social Security Number at the time of your appointment. If you are unable to provide this information your appointment may be cancelled or rescheduled.

Prescription Refills: If you need a prescription refilled you will need to contact your pharmacy and request a refill request be sent to the office to be processed by the clinical staff and approved by the physician. Refill authorizations may take up to 48 hours to be completed. Please check the status of your medications with your pharmacy. If the medication you requested is not received by the pharmacy within the 48 hours timeframe please call the office.

Laboratory Test: If your insurance requires you use a specific lab to utilize your benefits fully please be sure to inform the nurse at the beginning of your appointment. Remember since we send all lab specimens to an outside lab we do not charge for the actual test; the lab will bill you separately if your insurance does not cover them.

Result Notification: We will make every effort to notify you of results whether they are normal or abnormal. A phone call will be made to all patients regarding abnormal results. Generally all normal results will be posted to the patient portal for patients to access at their convenience. Please allow one week for result notification. If you have not received notification of your results after one week please call the office.

Telephone Calls: During office hours while the physician is attending other patients it is necessary for the staff to take detailed messages and pass along to the physician. If you are experiencing an emergency you will be advised to call 911 for assistance. If your call is of urgent nature a nurse will triage your call and consult the physician. Calls deemed non emergent will be handled by the office staff in the order they were received. If a call requires the physician to call you back it may be during lunch hours or after patient appointments.

Transferring of Records: All requests for medical records must be in writing and must adhere to all HIPAA requirements. All patients will receive one free copy of your medical records. If you require additional copies we will assess a fee according to the state statutes of $25.00 for the first 20 pages and $0.50 for every subsequent page.

General Consent to Treat

I, the undersigned, hereby consent to the following: Administration and performance of general treatments, use of prescribed medications, performance of diagnostic procedures/test and cultures, performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of my physician or their assigned designees. I fully understand this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended.

A photocopy of this consent shall be considered as valid as the original. I understand this form may include consent at other satellite offices under common ownership. I understand that while my consent is voluntary, if I refuse to sign this consent, the healthcare providers of **Comprehensive OB/GYN** may refuse to treat me. I understand these services are voluntary and I have the right to refuse these services.

I certify I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patients Name _____ **Date of Birth** _____

Patient/Responsible Party Signature _____ **Date** _____