Acct #: _____ Patient Name: _____ Date of Birth: _____

Miami OB/GYN, LLC

Payment Policy and Financial Agreement

We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive the maximum allowable benefits under your policy. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

- When collecting Cord Blood there will be a $250.00 doctor's fee you will be responsible for.
- When we are participating providers with your insurance company referral forms, and/or pre-authorization, co-pay, coinsurance, or deductible is due at the time of service.
- We pre-approve the surgical procedure with individual insurance carriers to determine benefits. Surgical procedures may require a deposit, including deductible and/or co-pay. Remaining balances are to be paid within one month of settlement with your insurance company (unless arrangements for pre-payment on a monthly payment schedule have been made in advance.)
- The undersigned agrees whether he/she signs as parent, spouse, guarantor guardian, or patient, that in consideration of the services to be rendered to the patient he/she hereby individually obligates himself/herself to pay the accounts. Should the account be referred to an attorney collection, I authorize the attorney to obtain my credit report: and the undersigned shall pay reasonable attorney's fee and collection expenses.

Important: Some plans require patients to obtain referrals and/or pre-authorization for services provided at out- side facilities. In such instances, the patient must notify our business office within 48-72 hours so that they may obtain the necessary referral or pre-authorization. If we are not notified and subsequently unable to obtain pre-authorization, you will be responsible for the bill.

We emphasize that as a medical care provider, our relationship is with you and not with your insurance company. We cannot be responsible for any loss of benefits. It is your responsibility to know your policy. If you have any questions concerning the above Information, please do not hesitate to ask us. We are here to help you.

I have read and understand this financial agreement and realize that all fees, regardless of the insurance coverage, are ultimately my responsibility.

I HEREBY AUTHORIZE THE RELEASE of any medical information necessary to process the direct payment of medical benefits to Miami OB/GYN, LLC.

_____

PATIENT'S/GUARANTOR'S SIGNATURE **Date**

Patient Name: _____

Notice of Privacy Acknowledgement

- I acknowledge that the Notice of Privacy Practices is available**.**
  (If you would like a copy of the Privacy Practices, please request one at the front desk)
- I acknowledge that due to the current HIPAA laws my doctor is required to obtain a written consent to disclose any Private Health Information in the presence of anyone other than myself.

Please check the corresponding line:

_____ I ALLOW Miami OB/GYN, LLC to discuss details of my medical records/financial records with

_____

(Please print name of authorized family member or friend)

Relation (of authorized person) to patient _____

___ I DO NOT ALLOW Miami OB/GYN, LLC to discuss details of my medical records/financial records with anyone else but me.

_____ _____

Patient's Signature Patient's Name

_____

Date