OB-GYN HEALTH CENTER
Office Policies & Consent
****Initial after each Policy & Consent****

1. **Insurance Benefits:** Payment is expected at the time of service. This includes copays, co-insurance, and any remaining deductibles. **Please note**, all benefit information is provided to us by your insurance company. If there are any discrepancies with your benefits, we ask that **you** contact your insurance company. _____ **Initial**

2. **Financial Responsibility:** Upon checking in, our staff will inform you of your financial obligation for your appointment as well as any past due balances. Payment at that time will be requested. _____ **Initial**

3. **Delinquent Accounts:** Our office makes reasonable financial arrangements with our patients. These arrangements must be made with our billing/insurance department. If you have not made a financial arrangement and/or have not made an attempt to pay your obligation, your account will be placed in a collection status. Your account will be turned over by the practice to a debt collector. A fee in the amount of **35% of the total amount due**, will be added to your outstanding balance. _____ **Initial**

4. **No Show Policy:** Our office enforces a "No Show" policy. We ask that if you must cancel your appointment that you kindly give us a 24-hour notice. **New Patient appointment** "No Show" fee is **$50.00**. **Established Patient appointments** "No Show" fee is **$25.00**. The "No Show" fee is required to be paid before another appointment can be schedule. _____ **Initial**

5. **Surgical Fees:** At the time your procedure/surgery is scheduled our office will notify you your estimated financial obligation. Your obligation is expected to be paid no later than your pre-op visit. Failure to pay your portion may result in your procedure/surgery being reschedule. _____ **Initial**

6. **Insurance Processing:** Our office will file primary insurance plans ONLY. If you are submitting your own claim you will be given the information needed when you check out to forward to your insurance company. _____ **Initial**

7. **Medical Records:** There is a $1.00 per page for the first 25 pages, and $0.25 for each additional page. Allow 72 hours for your request to be fulfilled. Medical Record request can be printed from our website; ***obgynhealthcenter.org*** _____ **Initial**

8. **Completion of All Forms**: There is $5.00 Administration fee for each form. The fee is to be paid prior to completion of forms. ***Example: FMLA, Disability, etc.*** _____ **Initial**

9. ***Consent:*** I hereby consent to a medically indicated physical examination. This may include but is not limited to a pelvic examination. This consent will remain active until I withdraw my consent in writing. _____ **Initial**

I certify that I have read and understand the above office policies & Consent

_____ _____

Patient/Guardian Signature Date

_____ _____

Patient/Guardian Printed Name Patient DOB