Obstetrics & Gynecology
8950 SW 74 Court, Suite 2001
Miami, FL 33156
Phone: 305-661-7766 Fax: 305-661-0329

FINANCIAL RESPONSIBILITY

Patient Name: _____

Date of Birth: _____ Today's Date: _____

		Initials
1.	I understand that it is my responsibility to be knowledgeable about the scope of coverage that my insurance provides. I acknowledge it is NOT the responsibility of the doctor to interpret my benefits and assume responsibility for coverage. I understand my benefits for laboratory services order by the doctor and I understand that many of the services provided to patient are not considered medically necessary under their definition of this term, and I accept MY responsibility for all services provided by my doctor to me in this regard. I also understand that by allowing my blood to be drawn, I authorize the doctor to perform the recommended tests and I agree to assume all financial responsibility for these tests.	
2.	I understand that there are laboratory tests, and/or other services that will not be included or covered by your insurance company.	
3.	I understand that my insurance company may have a co-payment or deductible component of the bill and hereby agree to pay my doctor for that portion which I am deemed responsible.	
4.	I understand that, as a courtesy to the patients, the doctor may bill my insurance provider in those cases for which a relationship has been established between the insurer and my doctor. For instance, in cases of HMO managed care services, the doctor will collect a co-pay and any deductible fees and bill the insurer for services which it feels is covered as a benefit.	
5.	I understand that if the insurer denies payment for any reason, I will be full responsible for all outstanding charges. All benefits given to the patients are a quotation not a guarantee of payment.	
6.	I understand that occasionally my healthcare company may request a copy of my medical records in order to either audit the nature of my treatment or to determine the degree of benefits. I hereby give the office permission to release those records that may be requested.	
7.	I understand that I will be charged an additional $75.00 fee for any scheduled appointment that I fail to show up for, or if cancel an appointment less than one (1) business day in advance. I understand that I am fully responsible for this fee, since no insurance policy covers cancellation fees.	
8.	I understand that if I request my medical records, I will be charged a fee for photocopies. I understand that I will also be charged a $25.00 fee if I need any FMLA/Disability forms filled out by the doctor.	
9.	I understand that I will be charged a $35.00 for any returned check.	

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10.	I agree to pay all legal and other expenses that the doctor may incur as a result of actions taken to collect unpaid balances for which I am responsible.	
11.	I consent the doctor and the staff to communicate with me via e-mail regarding the following aspects of my medical care and treatment: prescriptions, appointments, billing, etc. I understand that e-mail is not a confidential method of communication. I further understand that there is a risk that e-mail communications between my physician and me or staff members regarding my medical care and treatment may be intercepted by third parties or transmitted to unintended parties.	
12.	I also understand that any e-mail communications between my physician and me or staff members regarding my medical care or treatment will be scanned and made part of my medical records. I understand that in an urgent or emergent situation, I should call my provider or go to the emergency room at the nearest hospital and not rely on e-mail.	
13.	I understand that in order for the doctor to be efficient in its billing practices it has requested that I provide a credit card number with my "signature on file". By doing so, I hereby give permission to the doctor to bill me by means of this credit card for all outstanding charges that are my responsibility. I understand that the office will try to collect these fees at the time services are rendered, but in those instances when I do not pay for these on the day of service, the office will bill my credit card. I understand the doctor will mail to me and explanation of any charge applied to my credit card within seven (7) calendar days.	
14.	I understand that virtual consults are provided by my doctor if needed. I further understand that these consults are subject to the terms and conditions of my health plan.	

_____ MasterCard _____ Visa _____ American Express _____ Discover

Card Number: _____

Expiration Date: _____

CVV (3 digits on the back or 4 on the front): _____

Our office will inform you before we charge your credit card.

I, _____, have read and agree to the above thereby accepting financial responsibility for those services the office and my doctor provide to me.

Patient Signature Date

We appreciate your compliance with our office policy.