OBGYN By the Sea, LLC

Thank you for choosing OBGYN By the Sea, LLC as your health care provider. We are committed to your treatment being successful. Please understand that your payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy, which we require for you to read and sign prior to any treatment.

ALL COPAYMENTS AND/OR DEDUCTIBLES ARE DUE PRIOR TO YOU VISIT

We accept: cash, check, major credit cards: Visa, MasterCard, and Discover Card

INSURANCE: *we will bill your insurance company for your visit AS COURTESTY TO YOU. Due to the difficulty obtaining payment from your insurance plans, we may ask for your assistance in getting your claim paid. Please be advised that it is the patient's responsibility to verify that we are a participating provider with your insurance plan.*

HMO/ REFERRALS*: it is your responsibility to obtain a referral from your primary care physician if you insurance carrier requires it for your visits. It is the patient's responsibility to know and understand the requirements of their insurance plan. Our office is not responsible to obtain referrals for patients on HMO plans****. If you arrive without a referral for your visit and are required to bring one, your appointment will be rescheduled.***

MINOR PATIENTS: *the parent or guardian accompanying the minor is responsible for payment of the bill.*

RETURNED CHECKS*: checks returned for any reason will be subject to all bank fees charged to us along with 5% of the face value of the check or $25.00 administrative fee (Whichever greater).*

COLLECTIONS*: should your account become a collection problem, the patient/ debtor assumes all costs of the collection including but not limited to collection agency fees, court costs, interest, and legal fees. All unpaid accounts will be reported to the credit bureau.*

NON-COVERED SERVICES: *You will be responsible for your payment of services "NOT COVERED" by your insurance plan. It is your responsibility to understand your insurance plan's benefits and/or limitations.*

I HAVE READ AND FULLY UNDERSTAND THE FINANCIAL POLICY. I herby agree to render payment in the accordance with the terms and conditions set forth.

Patient/Responsible party signature _____Date:_____

Print Patient Name: _____