YAVAGAL UROGYNECOLOGY: SUJATA YAVAGAL, MD

Thank you for choosing **Yavagal Urogynecology** for your medical care. We appreciate that you have entrusted us with your health care and we are committed to providing you with the best patient care possible.

Because healthcare benefits and coverage options have become increasingly complex, we have developed this financial policy to help you better understand your responsibilities as a patient. Your health insurance policy is a contract between you and your health insurance company. Please note it is your responsibility to know if your insurance has specific rules or regulations, such as the need for referrals and/or pre-authorizations. You should be knowledgeable of any deductibles, copayments and/or coinsurance.

If you are uncertain about your current health insurance policy benefits you should contact your plan to learn the details about your benefits, out-of-pocket expenses, and coverage limits.

Insurance Coverage
Please provide us with your current insurance card at the time of each visit and notify us of any changes. We will request a copy of your insurance card to copy and keep on file for our records.

Please be aware of and provide any required referrals or authorizations in advance of the appointment. If you do not provide these before care is provided, you will be responsible for the cost of the care. When in doubt, contact your plan directly for clarification.

Dr. Yavagal belongs to many insurance plans. Before your appointment, she is in-network and the services are covered under your plan. If your doctor is out-of-network, you will be billed for the costs of care.

Address Change
Please advise us anytime there is any change to your address, telephone or other contact information.

Co-payments/Co-insurance/Deductibles
You are expected to pay your co-payment and any co-insurance and/or deductible amounts, if known, at the time of service. We will also collect all previous outstanding patient balances at the time of your visit. All co-payments and past due balances are due at the time of service. We accept cash, check or credit cards.

We will bill your insurance. Once they have paid, you will receive a bill for the remaining amount owed. The balance is due in full within 30 days of receipt of the statement.

Self-Pay
Self-pay accounts are patients without insurance coverage. It is your responsibility to know if our office participates with your plan. Self-pay patients are required to pay the estimated amount due at the time of service.

Non-Covered Services
Medicare Patients. Medicare may not cover some services your doctor recommends. You will be informed ahead of time and given an Advance Beneficiary Notice (ABN) to read and sign. The ABN will help you decide whether you want to receive services, knowing you are responsible for payment. You must read the ABN carefully.

Non-Medicare Patients. Any service not covered by your plan is your responsibility and must be paid in full at time of service. If unable to pay in full, please speak with us to arrange acceptable payment arrangements.

Non-Medical Fees
Additional fees may apply to the following:
Returned Checks – There will be a $25 fee assessed on returned checks.
Missed Appointments – We require a 48 hour notice of appointment cancellation. Appointments missed that are not previously cancelled will be charged a fee of $50.

Consent of Treatment
I, the undersigned, authorize the physician assigned, as provided by law, to furnish medical or surgical treatment to the patient, as he/she considers necessary and proper in the treatment of the patient for the purpose of treating his/her medical condition.

Assignment of Benefits and Responsibility to Pay
I hereby assign all medical and surgical benefits to which I am entitled. I have also read and understand the financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

I certify that I fully understand the nature of the above financial and cancellation policy and agree 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 account. Should the account be referred to an attorney for collection, I authorize attorney to obtain my credit report and the undersigned shall pay reasonable attorney fees and collection expenses.

Date : _____ /_____ /_____ **Print Name of Patient:** _____

Signature of Patient (or responsible party): _____