

Financial Policies & Agreement

We are pleased that you have chosen us to provide your gynecological and/or obstetrical medical care. Following are our financial policies for our practice.

Basic Principles

1. Our practice is a business concern. Our "business" is to render professional services to our patients (clients). In order for a business to continue to operate, certain financial expenses must be met. Among these are salaries for employees, rent, insurance, supplies and equipment, and repairs and maintenance.
2. Our expenses can only be met if we receive compensation for our services. We have no other source of income.
3. Each patient is fundamentally and personally responsible for the financial cost of our services. Insurance plans are to assist with this responsibility. You will be held responsible for (1) balances assigned to you by your insurance plan and (2) items not paid within 90 (ninety) days by your insurance plan.
4. Physicians are NOT responsible for coverage decisions made by insurance plan or by employers who sponsor such plans.
5. Most insurance plans currently involve discounted contracts with physicians. We agree to accept discounted payments from the plan in exchange for appearing on the plan's list of "preferred providers". The discount involved depends on the plan and on the specific service. Some discounts are very small, and some are very large (sometimes not at a level that allows us to meet our expenses).

Financial Policies

1. Patients without insurance are expected to pay all charges in full at the time services are rendered.
2. We accept checks, money orders, cash, credit cards and debit cards. Please use cash only here in the office, never send cash in the mail. If paying in cash, it is your responsibility to make sure you receive a receipt.
3. Current insurance information is absolutely vital. It will be your responsibility to provide your current insurance ID card at the time of service.
4. Office visit "co-payments" must be made at the time of the appointment. We reserve the right to require you to pay a \$15.00 service charge if not paid at the time of service.
5. We always send an appropriate claim to your insurance plan within 14 (fourteen) days of the date of our services. By Colorado Law, your insurance then has 30 days to process the claim. Failure to process a claim in such a timely fashion is a violation of Colorado Law. (A check, if any, from the insurance plan is usually attached to our EOB).
6. Once we receive the EOB, our billing personnel enters the appropriate data into your account in our computer. A "balance bill" is sent to you ONLY if (1) we have been instructed to do so by your insurance plan, or (2) ninety days have elapsed with no action being taken by your insurance plan.
7. You are responsible for paying all of the balance due on your account within 30 (thirty) days of our original statement to you. We will send the first statement to you as a courtesy. However, for each additional monthly statement that we have to send to you, we resend the right to add a "re-billing" charge (currently, \$10.00). Such charges may be added retroactively.
8. Some obstetrical patients may be required to pay an estimate of the patient's share of our charges in advance of the delivery. In these cases, we expect to receive regular payments towards this estimate at each prenatal appointment.
9. "Insufficient funds" or "closed account" checks returned to us by your bank will be handled as follows: (1) we will assess a \$25.00 charge to your account. (2) We will attempt to contact you to find out how you would like to handle the situation. (i.e. pay by credit/debit card over phone) (3) If the check is submitted again, and is again returned, another \$25.00 charge to you will occur and we will require you to either pay by credit/debit card or come to the office to remit, in cash, the entire balance then due.
10. DELINQUENT ACCOUNTS. Any account with a balance more than 30 (thirty) days old is deemed delinquent. We then begin a series of steps in an attempt to collect the amount due. Please contact us if you are having financial trouble or if you do not understand your account. The final step is legal collection action, which we do NOT want to take against any patient. We will ADD a 35% (thirty-five per cent) "collection fee" to any account that we have to turn over to a collections agency or attorney. By your signature below, you are agreeing to be responsible for this "collection fee". Finally, the collections agency or attorney has the right to assess additional fees, costs, attorney's fees and interest- you are also agreeing to be responsible for these where applicable.
11. NO SHOW/CANCELLATION POLICY. Our office charges \$50 for no shows or cancellations within less than 24 hours of scheduled appointment time.

I understand this statement of policies and this Agreement. I agree to be bound by the terms and conditions above.

Signature of Patient or Responsible Party

Printed Name of Patient

Date