

HENDERSON OB/GYN

129 W LAKE MEAD HWY. STE. 19 ✦ HENDERSON, NV 89015

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FINANCIAL POLICY

Welcome to *Henderson Ob/Gyn*. The following outlines our patient financial responsibility policy.

Payment for services provided by *Henderson Ob/Gyn* is required at the time of service unless prior arrangements have been made. Co-pays and non-covered services are due at the time of service. If we are contracted with your primary/secondary insurance company, we will bill your insurance company for you. It is your responsibility to determine what services your insurance will cover and whether a referral is required for you to be seen at *Henderson Ob/Gyn* or by another provider. If you need to be referred to a specific laboratory or cytology lab, it is your responsibility to communicate this information to the physician.

If *Henderson Ob/Gyn* is **not contracted** with your insurance company and you need a major medical service (such as having a baby or needing surgery), we will provide you with the opportunity to meet with our office manager. She can help you estimate the cost of the medical services supplied by *Henderson Ob/Gyn*. A financial agreement form will be completed which should include the cost of the surgery, any deductible due, an estimate of your insurance payment at out-of-network rates and an estimate of the amount that you will need to pay for the service. Financial arrangements can be discussed in advance so that a specific payment plan can be arranged if necessary. As a courtesy, we will bill your insurance for you. When you receive the statement for your services, you are responsible for payment at that time.

All medications and medical supplies provided by *Henderson Ob/Gyn* should be completely paid for at the time of service. Services provided by outside laboratories such as the reading of PAP tests and/or biopsies will be billed directly to you by the outside provider.

Payment is expected at the time of service. You will receive a statement showing in detail charges incurred during the statement period and the amount due. Any uncollected fees are payable within 30 days of receiving the statement. As the patient, you are responsible for complete payment of any charges that you incur whether covered by your insurance or not covered by your insurance. A finance charge of 1.5% per month (annual percentage rate of 18%) will be made 90 days following the date of services were provided. If your account becomes delinquent and referred to a collection agency, you will be responsible for the costs of collection and/or legal fees.

MY SIGNATURE BELOW INDICATES THAT I HAVE READ AND UNDERSTAND THE BILLING POLICIES OF HENDERSON OB/GYN AND AGREE TO COMPLY WITH THEM.

I AUTHORIZE HENDERSON OB/GYN TO RELEASE TO MY INSURANCE CARRIER AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THE BENEFITS PAYABLE UNDER THEIR COVERAGE. I FURTHER AUTHORIZE MY INSURANCE COMPANY AND ITS CARRIERS TO DISCLOSE ANY INFORMATION REQUESTED REGARDING CLAIMS FOR MEDICAL BENEFITS TO HENDERSON OB/GYN A COPY OF THIS AUTHORIZATION MAY BE USED IN PLACE OF THE ORIGINAL.

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICAL BENEFITS BE MADE ON MY BEHALF TO HENDERSON OB/GYN FOR SERVICES FURNISHED TO ME BY ITS PHYSICIANS AND STAFF UNLESS I HAVE PAID FOR THE SERVICES AND AM BILLING THE INSURANCE DIRECTLY.

PATIENT NAME (please print) Social Security Number

PATIENT SIGNATURE Date

Credit Card Signature on File Authorization

Please complete this form and retain a copy for your records.

I authorize Henderson Ob/Gyn to keep my signature on file and directly charge my credit card account for:

- Charges I personally incur
 Charges by family members listed below:

 Monthly payments of \$ _____ for _____ months

Check one:
 Mastercard Visa

Credit Card Number Expiration Date

Cardholder Name Date

Signature