SOUTHEAST TEXAS OB/GYN ASSOCIATES, P.A.
FINANCIAL POLICY

Southeast Texas OB/GYN Associates, P.A. believes that part of good healthcare practice is to establish and communicate a financial policy to our patients. We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policy.

PAYMENT is expected at the time of your visit. We will accept cash, check, or credit card. Payment will include deductible, co-insurance, co-payment amount, or non-covered charges from your insurance company. All past due balances are due at time of check-in unless previous arrangements have been made with our business office.

INSURANCE is a contract between you, your employer and the insurance company. **We are not a party to that contract**. It is very important that you understand the provisions of your policy. It is your responsibility to verify that we are an in-network provider on your specific plan. Insurance plans vary considerably, and we cannot predict or guarantee what part of our services will or will not be covered. It is the responsibility of the patient to provide ***accurate*** and ***timely*** insurance information. Therefore, we ask you to ***bring your current insurance card and driver's license to each visit***. Inaccurate or untimely information given to the staff that results in denial or non-coverage by your insurance company will result in the guarantor being responsible for payment.

If you have insurance coverage under a plan with which we do not have a contract, or if you are un-insured, you will be required to pay ***in full*** at the time of service for all office visits and/or procedures. You may be given a same-day discount for most services when full payment is received. Some exclusions may apply due to cost of medications, etc.

The parent(s) or guardian(s) accompanying a minor are responsible for providing current insurance information for the minor as well as the payment in full for services provided.

Initial:_____________

BILLING: Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits. You should call your insurance company for any questions regarding how they processed your claim(s). You may call the billing office for any other questions regarding your bill or to discuss payment options.

Effective January 1, 2013: If payment arrangements are necessary, they must be made immediately with our billing office. An initial payment of at least ***25% of the full balance owed*** will be required. Any account balance outstanding longer than ***90 days*** will be charged a ***$15 per month*** billing fee and may be forwarded to a collection agency. In the event an account is placed with an agency for collection purposes, the patient will be responsible for all collection agency fees (up to 35% of the balance placed for collection). In addition, the patient will be responsible for all court costs, filing fees and attorney fees should this account require litigation.

Patients with a delinquent account must be paid in full prior to receiving services from our staff or physicians.

RETURNED CHECKS: A $30.00 fee will be charged for any checks returned for insufficient funds. You will be asked to bring cash, certified funds or a money order to cover the amount of the check plus the $30 service charge.

Initial:_______________

FORM FEES: Completing disability insurance forms and employer forms is not a medical service and is not paid by insurance. It requires office staff time and time away from patient care for our doctors. However, we provide a complementary service of preparation of one set of forms for our patients. We require pre-payment of $15 for each additional form. Please provide at least 2 weeks notice or lead time for completion.

We welcome the opportunity to discuss any aspect of our financial policy. If you have any questions, please contact our Business Office at (409) 899-1499 ext. 6188.

I have read and understand the above financial policy of Southeast Texas OB/GYN Associates, P.A. and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice at any time without prior notification to the guarantor.

______________________________	______________________________	______________
Patient Signature	Printed Name	Date

Consent for Release of Protected Medical & Billing Information

_____ I will allow ALL results including ABNORMAL results to be released to the following:

______________________________	____________________
Name	**Relation**
______________________________	____________________
Name	**Relation**

______I will allow INSURANCE AND BILLING or information to be discussed regarding my ACCOUNT with the following:

______________________________	____________________
Name	**Relation**
______________________________	____________________
Name	**Relation**

______I will allow SCHEDULING APPTMNTS to be discussed with the following:

______________________________	____________________
Name	**Relation**
______________________________	____________________
Name	**Relation**

_____May leave message on: (circle one or both) answering mach (home) voice mail (cell)

_____I do NOT want ANY test results released to anyone but MYSELF.

____
Printed name of patient

____
Signature of patient

____
Date

******This consent will expire one year from date above**