



Patient Financial Disclosure

Business Office • Phone 208.955.0350 • Fax 208.955.0352

Thank you for selecting OB/GYN Associates for your women's health care needs! We are committed to providing you with the best possible health care! The following information is provided to ensure you are aware of our financial policies and to avoid any misunderstanding concerning payment for professional services. Please ask one of our team members if you have any questions regarding these policies.

- Our office participates with a variety of insurance plans. It is your responsibility to:
 1. Bring your insurance card at every visit;
 2. Be prepared to pay your co-payment, co-insurance and/or deductible at each visit. Payment may be made by cash, check or credit card. We accept VISA, MASTERCARD, DISCOVER & AMERICAN EXPRESS credit cards for your convenience. We convert checks electronically upon presentation. You may also arrange for auto-pay on your credit card for all services or remaining balances after insurance for your convenience.
 3. For medical care not covered under your insurance, payment in full is due at the time of the visit.
- We will bill your insurance as a courtesy; however, all charges, regardless of insurance coverage are your responsibility. If your insurance has not paid within 30 days, please contact them to ensure prompt resolution of your bill. Please visit our website at www.obgynidaho.com for a list of insurance plans with whom we contract or to pay your bill online.
- If you do not have insurance or other benefits, you will need to provide a \$100 deposit for services upon registration for your visit. If you pay in full for your visit at the time of service, you will receive a 10% discount.
- If the patient is a minor (18 years and younger), the parent or guardian must sign below. The parent, guardian or unaccompanied minor is responsible for any payment due at time of service, bringing necessary referrals & insurance card.
- If you are unable to pay for necessary medical care, you may be eligible for financial assistance or a payment plan. It is your responsibility to inform us prior to the visit. Please ask to discuss arrangements with our business office. We ask that you provide an automatic payment source such as credit card or bank draft for payment plans.
- Referrals: It is your responsibility to bring any required referrals for treatment at, or prior to the visit. If you do not have a referral, your visit may be rescheduled, or you may be financially responsible.
- If you are seen for both a wellness visit or annual exam *and* an illness or separate problem is also addressed, proper coding will be used which may result in a charge for both services. Additionally, some medically indicated lab work may *not* be covered by all wellness policies. Your individual contract with your insurance carrier will determine how your insurance will pay. We make every effort to bill each visit with the proper diagnosis and procedure codes according to national coding guidelines. Please understand that we cannot make exceptions to our coding practices due to federal and state legal compliance concerns, and we are unable to bill for services other than those documented in your medical record.
- For obstetrical care, if you have confirmed insurance we ask for a \$200 payment at the first office visit. If you do not have insurance or other government benefits, we ask for a \$600 payment at the first visit, and an additional \$600 by your 18th week of pregnancy. We will then arrange a contract with you for a monthly payment based on your estimated financial responsibility after insurance and other benefits are verified. Automatic payment options are available.
- We routinely send our PAP and pathology tests to outside labs for processing; therefore you will receive a separate bill from the pathologist's office. These providers may or may not participate with your health plan.
- If you fail to make payment in full for the services that are rendered to you, your outstanding balance will be sent to a collections agency. You will be responsible for the fees assessed by the collections agency.
- There will be a charge for the second scheduled appointment that you miss (no show).
- A \$20.00 service charge is applied to all returned checks. Finance charges will accrue on balances over 90 days at a rate of 1.5% per month (18% per annum).

I have read and understand the above information and agree to comply with these financial policies.

Signature _____ Date _____

Patient Name: _____ Account #: _____