

Southern Obstetric & Gynecologic Associates

Financial Policy

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you read and sign prior to treatment. **However, this Policy does not apply to Medicare patients.**

All patients must complete our Information and Insurance forms before seeing a doctor or nurse practitioner.

FULL PAYMENT IS DUE AT TIME OF SERVICE.

WE ACCEPT CASH, CHECKS, or VISA/MASTERCARD/DISCOVER.

Regarding Insurance

Participating Provider: All co-pays and deductibles are due prior to treatment. Please be aware that some, and perhaps all, of the services provided may be “non-covered” services and therefore you will be responsible for the balance of your bill.

Other Insurance: Payment is expected at the time of service. We will bill your insurance, so that you can be reimbursed, if complete information is provided. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract.

If your insurance company has not paid your account in full within 45 days, the balance of your bill will automatically become your responsibility.

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company’s arbitrary determination of usual and customary rates.

Missed Appointments

Unless canceled, at least 24 hours in advance, we reserve the right to charge for missed appointments at the rate of a normal office visit. Please help us serve you better by keeping scheduled appointments.

Interest

We reserve the right to charge interest to overdue accounts as provided by state law.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns.

I have read the Financial Policy. I understand and agree to this Financial Policy.

_____ **Date:** _____
Signature of Patient or Responsible Party