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Capital OB/GYN

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FINANCIAL RESPONSIBILITY AGREEMENT

PATIENT NAME: _____ DATE OF BIRTH: _____
Please print *MM/DD/YYYY*

We appreciate that you have selected Capital OB/GYN, Inc. to provide your OB/GYN care and look forward to serving you. We intend to provide you with exceptional care and service. Listed below are some billing and office guidelines to help us work with you in the best possible way.

I understand and agree that I will be financially responsible for any and all charges for services not paid by my insurance for my visits. I understand that once a claim has been submitted to my insurance carrier, the office will not change the coding in order to circumvent an insurance denial.

I understand and agree it is my responsibility and not the responsibility of the Physician or Capital OB/GYN, Inc. to know if my insurance will pay for my medical services or visits.

I understand and agree it may be necessary to obtain tissue or perform lab tests to confirm a diagnosis or to determine a course of treatment. If any tissue is removed for a pathology examination or if a laboratory test (Pap smear, culture, etc.) is done in the office, the actual test is usually carried out by someone else. This means I MAY RECEIVE A SEPARATE BILL FROM PATHOLOGIST OR LAB FOR THESE TESTS. It is necessary to contact that lab directly to resolve any billing concerns.

I understand and agree it is my responsibility to know if the physician or provider I am seeing is a contracted in-network provider recognized by my insurance company or plan. If the physician or provider I am seeing is not recognized by my insurance company or plan, it may result in claims being denied or higher out of pocket expense to me. I understand this and agree to be financially responsible and make full payment.

I understand and agree it is my responsibility to know if my insurance has any deductible, co-payment, co-insurance, out-of-network amount, usual and customary limit, or any other type of benefit limitation for the services I receive. I understand that I will be asked to pay my co-payment, deductible and co-insurance amount AT THE TIME OF SERVICE. I understand that I can only know of the exact cost of a procedure when the doctor has determined the actual code being used and the claim is processed by insurance company.

I understand that if I make a payment by check to the office, and it is returned to the office for any reason, I will incur a **fee of $25**. Additionally, I will be responsible to pay the balance in full beforeI can receive non-emergent care.

➘ **SIGNATURE** _____ **DATE** _____
MM/DD/YYYY

☐ IF NOT SIGNED BY THE PATIENT, PLEASE INDICATE RELATIONSHIP AND AUTHORITY: _____

PRINTED NAME OF PERSONAL REPRESENTATIVE: _____