Biltmore OB-GYN is committed to providing you with quality and affordable health care. In order to assist our patients in understanding patient and insurance responsibility for services rendered, we have outlined our financial policy below. Your understanding of our financial policy is essential.

**Insurance**: You must realize that your health benefit plan is an arrangement between you and the insurance company, HMO or your employer. We participate in most managed care plans. We will file a claim to your insurance company on your behalf. You must provide us with your current insurance card and notify the office immediately after any changes to your insurance coverage. Regardless of insurance status, if your insurance company does not pay, fails to pay timely, or denies a claim, you will be responsible for the charges incurred. Initials ________

**Copays and Deductibles**: You are required to pay for your visit at the time of service. Payment is accepted with cash, check, Visa and Mastercard. It is your responsibility to know and understand your coverage and benefits. Fees collected by us at the time of service are only an estimate of cost. Actual benefits cannot be determined by us, but will be applied by your insurance carrier at the time the claim is processed. Should a situation arise which makes it impossible for you to pay for the services in full at the time of service, we request that you contact our office prior to the appointment to discuss payment arrangements. Initials ________

**Non-Covered Services**: Some routine screenings and diagnostic testing, including but not limited to: pap smears, preventive service/well woman exams, contraceptive management, 3D ultrasounds, and certain injections may not be covered by some insurance carriers. You will be responsible to pay for services that are not paid by your insurance company. You will also be responsible for any charges related to copies of medical records, as we can not file this to your insurance. Initials ________

**Ancillary Services**: Labs, Paps and other specimens are sent out to a laboratory. PML and Mission Lab will bill separately for these services. If you receive a statement from an outside laboratory, please call them directly for any questions. Initials ________

**Other Services**: All services provided outside this office, even though ordered by our physicians, are billed by the provider of this service-not our office. If you have surgery at the hospital or outpatient surgical center, you will receive additional bills from them. Please verify your insurance benefits for coverage of other facilities and providers. Initials ________

**Returned Checks**: The return check fee is $25.00 and will be assessed each time the check is returned. You will be contacted concerning the problem but it will be re-deposited if there is no response. Initials ________

**Missed Appointments**: Biltmore OB-GYN requires a 24-hour notice to cancel an appointment. If you fail to cancel an appointment within the 24-hour timeframe, you may be charged a $25 no-show fee. Initials ________

**Minors**: The responsibility for payment of service rendered to minor children (under 18) rest with the individual bringing them to the appointment. If a minor comes to an appointment and has no means of payment, the visit will not be rendered. Prior payment arrangements need to be made by the legal guardian or parent. In the event of divorce, the parent who brings the child to our office for care pays for the services. Initials ________

**Collections**: Accounts with a balance over 60 days old will be considered delinquent. Our office will attempt to collect this balance through statements and collection calls. Therefore, if for any reason you are unable to settle your account within 30 days, it is imperative that you contact our business office to establish payment arrangements. It is important to note that any balance over 90 days old may be placed with a collection agency. A 1.5% monthly finance charge will be assessed to all accounts with a past 90 days. If you disregard our collection attempts, we can only assume that you do not intend to pay for the medical services that were provided to you in good faith, thus our professional relationship could be dissolved. Initials ________

*Please sign that you have read and agree to the financial policies and procedures.*

Patient's Name:__________________________________________________________ Date of Birth:______________________________

Signature of Patient or Responsible Party:_____________________________________________ Date: ______________________________

US FINANCIAL AGREEMENT 6/13

Patient Acct # __________________