



Financial Policy/Cancellation Policy

Thank you for choosing us as your healthcare provider. We are committed to you and your healthcare needs. Please understand that payment of your bills is considered part of your care. The following is a statement of our financial policy. We require that all of our patients read and sign it prior to treatment or consultation.

All patients must complete our information and provide insurance information before seeing the doctor/provider.

PAYMENT IN FULL IS DUE (UPON REQUEST) AT THE TIME OF SERVICE.

For your convenience, we accept Cash, Credit or Debit cards.

(Please initial after each number.)

1. ____ It is the responsibility of the patient to confirm that the physician/provider is participating with the insurance plan and that your benefits are active. Our office will file claims to your insurance company for professional services rendered. We cannot bill your insurance carrier unless you give us your current insurance information. Please remember, **INSURANCE COVERAGE IS A LEGAL CONTRACT BETWEEN THE PATIENT AND THE INSURANCE COMPANY.** Benefits may differ depending upon what type of contract you have with the carrier. If your insurance company has not paid your account in full at the end of 90 days, the balance will automatically be transferred to your responsibility for payment in full. Please be aware that some or perhaps all the services provided may be non-covered services and not considered necessary under the Medicare Program or other medical insurances.
2. ____ All **co-pays and deductibles are due at the time of treatment.** We require payment in full for your portion (coinsurance, deductible or out-of-pocket fees) at the time of service. In office we accept Visa, MasterCard, Discover, American Express and cash. If a check is returned from your bank, there will be a **\$40** returned check fee added to your total amount due. Ultimately, you are responsible for all charges incurred in our office. The insurance contractual obligation does not allow us to write off co-pays or deductible amounts.
3. ____ As a courtesy, we have contacted your insurance company to verify benefits. Based on this provided information, we are able provide your estimated patient responsibility for services rendered. This is an estimate and not a guarantee of benefits. There may be additional charges once claims have been processed by your insurance company.
4. ____ If the patient cannot keep the scheduled appointment, **it is the patient's responsibility to give our office at least 24 hours cancellation notice.** We reserve the right to charge an **\$85.00** fee for missed or cancelled appointments with less than 24 hours notice. Please help us serve you and other patients better by keeping scheduled appointments.
5. ____ The patient understands that if their account balance is over 90 days past due, their account will be in default and may be referred to a collection agency. If this occurs, the patient may lose the ability to be seen until their account is paid in full.
6. ____ All lab procedures are done by an outside lab and will not be included in the charges for Modern OBGYN. All lab tests performed are billed separately by the outside lab. The patient understands that all charges not covered by insurance is the patient's responsibility. The patient will direct any questions regarding a bill or statement from the outside lab to the lab directly.

I HAVE READ AND UNDERSTAND THE OFFICE POLICY STATED ABOVE AND AGREE TO ACCEPT FINANCIAL RESPONSIBILITY AS DESCRIBED ABOVE.

Patient, Legal Guardian or Responsible Party Signature

DOB: ____/____/____

Today's Date: ____/____/20____

Revised 04/2023