FINANCIAL POLICY

Patient Name: ____ Date of Birth: ______/ _______/ ________

All co-payments, co-insurance, deductible, non-covered services, or any patient responsibility is due at the time services are rendered. If you are covered by a plan in which we participate as a provider, we will file your insurance claim. In the event that your insurance carrier does not pay the balance, we will notify you so that you may contact your insurance carrier or resolve your account. In the event that your coverage has changed, lapsed, or expired on the date services are rendered, all charges will be denied and become the patient's responsibility.

Co-payments, Co-insurance, and Deductibles: Insurance contracts obligate patients to pay their patient portions and providers to collect these amounts. **Please be prepared to pay these amounts at the time services are rendered.**

Medicaid Primary: As of January 2014, we are no longer accepting Medicaid. This includes the MSCAN Program carriers Magnolia and UnitedHealthcare.

Medicaid Secondary: As of January 1, 2013 we **no longer** accept Medicaid as secondary insurance unless the patient has Medicare as their primary insurance.

Out of Network Plans: Payment is due in full at the time services are rendered. As a courtesy, we will file a claim to your insurance carrier on your behalf or provide you with a claim for filing.

Self-Pay Patients: Payment is due in full at the time services are rendered.

Secondary Insurance: We will file secondary claims if we are participating with the insurance carrier network. If we are not participating, we will provide the patient with a claim form. **If your insurance carrier does not process the claim within 45 days of the claim being filed, the balance becomes the patient's responsibility.**

PLEASE READ AND INITIAL EACH BLANK.

_____Patient agrees to pay for all portions of services due in full at the time services are provided by our office.

_____Patient must advise office personnel of any insurance changes in a timely manner.

_____If account balances are not paid according to terms, the patient understands that our office reports all outstanding balances to an attorney. In the event that your account is turned over for collections, the patient agrees to pay all additional fees accessed in the collection of the debt. These fees include attorney and court fees.

_____I understand that a cancellation fee of **$25.00 will be charged** if I do not cancel or rescheduled within 24 hours of the scheduled appointment time. Exceptions will be determined at the discretion of the Office Manager.

_____ I understand that Madison OBGYN Associates **only accepts** payments via cash, debit card, or credit card

Patient/Guarantor Signature: ____ Date: _____/_____/_____