ALBANY OBSTETRICS & GYNECOLOGY, P.C.

Financial Policy

Thank you for choosing us as participants in your healthcare. We are fully committed to providing the highest level of healthcare to you, but please understand that in order to do this, we must collect payment for our services. Please read our financial policy outlined below and sign it prior to your treatment. Thank you for your understanding.

If you have insurance:

If we are participating providers in your insurance plan, you will be responsible only for that portion of the bill that your insurance indicates belongs to you. Co-payments are due at the time of your visit. If we do not participate with your insurance, any additional balances due after receipt of the insurance payment will be billed to you at no additional charge. It is your responsibility to understand the coverage benefits in your contract; we are not part of that contract. If payment is not received or financial arrangements are not made, the balance will be forwarded to a collection agency. Any fees incurred during that process would be your responsibility.

If we do not participate with your insurance we will bill your carrier as a courtesy, but the full balance due is your responsibility. Please be sure that you fully understand your coverage.

It is your responsibility to inform our office of any change in your insurance coverage.

Payment Arrangements:

We accept cash, check, Master Card and Visa. Special arrangements may be made in the case of financial hardship. Please contact a billing representative if you feel that this applies in your situation.

Fee Schedule:

Our fees are based on the usual and customary fees charged in this area. Patients are responsible for the balance owed regardless of your insurance carrier's determination of usual and customary for them.

I have read and understood this financial policy. I agree to the terms outlined above.

Patient Signature: _____ Date: _____

Patient Name: _____

Patient Date of Birth (mm/dd/yyyy): _____

If patient is unable to sign or is a minor, please sign as authorized person and indicate relationship to patient.

Date developed: March 15, 2003