Desert Perinatal ASSOCIATES

REMAINING BALANCE(S) AGREEMENT

Patient Name:_____ Account #:_____

As a courtesy, we verify your insurance plan benefits before your appointment(s). Based on the information we receive from your insurance company, we calculate the approximate amount of your co-pay(s), deductible(s) and/or co-insurance(s) due for the services rendered.

At times, your insurance company will provide us with different benefits information than they have provided to you. In these instances, we will make every effort to work with you and your insurance company to determine the correct balance(s) due for the date(s) of service in question.

I understand and agree to the following regarding my insurance plan benefits:

- I agree to pay the full amount(s) due based on the information I received from my insurance company.
- I understand that as a courtesy Desert Perinatal Associates will bill my insurance company for the date(s) of service in question.
- I understand that it is my responsibility to pay any and all balances not paid by my insurance company.
- I have previously read and signed a Financial Policy with Desert Perinatal Associates. An additional copy will be provided upon request.

Patient Signature:_____ Date:_____

DPA Signature:_____ Date:_____

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