Financial Policy

Patient Name: _____ D.O.B.: _____

I understand and acknowledge that my insurance coverage is a contract between me and my insurance company and that I am personally responsible for all medical expenses incurred during evaluation and treatment by the providers at Lone Tree Obstetrics & Gynecology.
I understand that as a courtesy my primary insurance will be billed; however, it is my responsibility to follow up on delinquent claims. If I am a member of a PPO or an HMO I am required to make my co-pay and co-insurance payments in a timely fashion.

CREDIT/DEBIT CARD, HSA (Health Savings Account), or CHECK ON FILE

It is the policy of Lone Tree Obstetrics & Gynecology to retain on file the payment account information for all active patients.
This information is kept strictly confidential and will only be used for payment of fees to Lone Tree Obstetrics & Gynecology.

Lone Tree Obstetrics & Gynecology will submit claims to your insurance company following your visit. Once the billing office receives final payment and/or disposition from your insurance carrier the office will bill your payment account on file for any amounts not paid by your insurance carrier that are considered patient responsibility. Examples of these amounts may be unpaid co-pays, co-insurance and deductibles. In many cases you will have already received an EOB (Explanation of Benefits) from your insurance company showing the unpaid amounts. This will in no way compromise your ability to question your insurance carrier's determination of payment.

Please familiarize yourself with our **No-Show/Cancellation Policy** as this $50 fee would be charged to your payment account on file.

If your balance due exceeds $300.00 Lone Tree Obstetrics & Gynecology will inform you of the amount to be charged to your account via secure email along with a personal phone call (please note that you will need to have a secure portal account with us in order to receive these email notifications). **Any other balances due under $300.00**, you will be notified by email on Tuesdays and then the funds will be deducted on Friday.

Authorization: *I authorize Lone Tree Obstetrics & Gynecology to charge my payment account for the balance of fees not paid by my insurance carrier.*

Choose your Method of Payment:

Name on Account (print) _____ Email Address _____

☐ Visa / ☐ MasterCard / ☐ Debit Card / ☐ HSA (Health Savings Account

Card Number __ __ __ __ - __ __ __ __ - __ __ __ __ - __ __ __ __ Expiration Date __ __ / __ __ __ __ CVC __ __ __

☐ Checking Account Bank Name _____

Bank Routing Number __ __ __ - __ __ __ - __ __ __ Checking Account Number_____

☐ Pre-Payment Plan – I Agree to a Pre-Payment Contract

☐ Pay at Time of Service

Signature _____ Date _____

CANCELLATION / NO-SHOW POLICY

You must notify Lone Tree Obstetrics & Gynecology no later than 12 noon the business day prior to your appointment to change or cancel your appointment. If notification comes in less time your account will be assessed a $50 cancellation fee. No notification of canceling or rescheduling your appointment will cause a $50 no-show fee to be added to your account.

LAST MINUTE CANCELLATIONS AND NO-SHOWS PREVENT OTHERS FROM GETTING TIMELY SERVICE.
THANK YOU FOR YOUR UNDERSTANDING.

I have read and understand the Cancellation / No-Show Policy for Lone Tree Obstetrics & Gynecology. I understand there will be a $50 fee added to my account for any appointments not cancelled or rescheduled by 12 noon the business day prior to my appointment as well as any appointments no-showed. I understand my payment card on file will be used to collect said charges.

Signature of Patient / Responsible Party: _____ Date: _____