Desert Perinatal ASSOCIATES

FINANCIAL POLICY

Patient Name_____ DOB: _____Social Security #_____

Responsible Party Name: _____DOB:_____Social Security #_____

Thank you for choosing us as your healthcare provider. The following is our Financial Policy. If you have any questions or concerns about our payment policies, please do not hesitate to ask.

Definition of Terms:

- Date of Service: the date any medical service is provided.
- Account Balance: the total amount due.

Guarantee of Payment: I hereby acknowledge I am responsible for the payment of all charges for services rendered to me or the patient indicated above, which I am the responsible party.

1. I understand that all deductibles, co-pays and applicable charges are due at the time of service. I understand all delivery/surgical fees must be paid in advance of the delivery/surgical date.
2. I understand this office filing a claim with my insurance company or other third-party payer, is a courtesy only. Under no circumstance, does the filing of a claim relieve me from my responsibility for the payment of all charges for services rendered.
3. I understand lab services are provided as a courtesy and all lab charges, including genetic testing, are my responsibility to pay.
4. By signing this document, I personally guarantee the payment of these charges for medical services rendered. I agree that this authorization shall be valid for all Dates of Service. We do NOT file claims for Workman's Compensation or claims due to personal injury accidents/illnesses.
5. I understand it is my responsibility to notify Desert Perinatal Associates, if my insurance benefits or insurance company changes.
6. I understand it is my responsibility to cancel my appointments at least 24 hours in advance otherwise, I will be charged a $25.00 non-cancellation/no show fee.

CONTINUED ON PAGE 2

Collection of Delinquent Account Terms: Failure to pay my balance within 30 days from any Date of Service is considered a delinquent account and may result in fees and interest being added to my Account Balance as follows:

1. Delinquent accounts 30 days past due will accrue interest at a rate of 24% per annum, until paid in full.
2. An account delinquent with any outstanding balances for 60 days may be forwarded and assigned to a collection agency at the patient's expense.
3. Any delinquent account assigned to any collection agency will be charged a collection fee, which upon assignment becomes the due and owing Account Balance. COLLECTION FEES ARE BETWEEN 40% and 50% OF THE BALANCE OWING AS OF THE DATE OF SERVICE, AND WILL BE ADDED TO THE OUTSTANDING ACCOUNT BALANCE WITH OR WITHOUT SUIT.
4. If legal action is required to collect this account, in addition to any Account Balance, I/We or the Patient's representative who signs below agrees to pay interest as set forth herein, plus all costs associated with such collection activity, including but not limited to all collection agency fees as set forth herein as part of the Account Balance, plus any and all attorney fees, court fees, skip tracing fees and costs in addition to any miscellaneous fees the court of jurisdiction may award.
   Collection Exceptions and Exemptions: allowed charges under Medicare Title XIX (Nevada Medicaid) contracts.

Returned Checks or Disputed Credit Card Payment: There is a fee of $35.00 for any returned check for insufficient funds. If a credit card payment is disputed and payment is wrongfully taken back from Desert Perinatal Associates by your credit card company, a $40.00 fee will be add to your account. These amounts may change at any time.

Assignment: If this account becomes delinquent, I/We hereby authorize this office to assign this account and/or release any necessary information to any third party collection agency. Additionally, if my account is assigned to any collection agency, I/We hereby authorize the collection agency the right to report this account as delinquent to all the Credit Bureaus.

Signature of Understanding: I have read and understand the financial policy. By signing this form, I consent to the above terms and conditions of treatment and understand that it is my responsibility for assuring that the financial obligation of my care is fulfilled. I hereby accept financial responsibility for all charges incurred whether or not I have insurance coverage.

X_____ _____

Signature of Patient or Parent/Guardian if Patient is under 18 year of age **Date**

X_____ _____

Signature and name of second responsible party for patient listed herein **Date**