Leslie S. Welborne, M.D.

Melissa Bailey, M.D.
Alisa Ward, M.D.

Centennial OB/GYN, P.A.

OFFICE POLICIES

At Centennial OB/GYN, we are dedicated to providing you with the best medical care available. In order to do that, we will need your assistance in providing us with necessary information. This information will be kept confidential and is protected by law. We hope you understand that the information provided is used for purposes of providing services to you and is shared only with the insurance company for the purpose of reimbursement. If any type of lab work is done, this same information will be provided to them as well. We will not release your information to any other facility or person unless requested by you in writing.

We will file your insurance if we are a participating provider under the plan for which you are enrolled. Any out of pocket expenses, copays, deductibles or co-insurance is the responsibility of the patient and are due at the time of service. If we are not a participating provider on the plan you are enrolled, payment will be due at the time of service. We accept checks, cash, Master Card, Discover, Amex & Visa. If a check will be used as payment, your driver's license must be provided.

_____ Your insurance is a contract between you, your employer, and the insurance company. We do file your claims as a courtesy only. The lab companies will file your lab claims. Ultimately, medical and lab charges are the responsibility of the patient.

_____ Unfortunately, we are not always aware of the particular details of each insurance plan. Therefore, please be sure you are aware of any exclusions and/or provisions with your plan. Any service not covered by the insurance will be the responsibility of the patient.

_____ Please be aware that out of network providers may provide all or part of any services performed outside the office of CENTENNIAL OB/GYN, P.A. These may include: labs, anesthesiologists, pathologists, radiologists, other physicians, or facilities, etc…

_____ **A copay will apply for Well Woman visits which address problems or require additional medical decision making, as a problem office visit will be billed as well.**

If you have any questions or concerns with these policies, please feel free to contact our office. This form must be signed prior to services being rendered. It will become part of your permanent record with our office.

Print Patient Name: _____ Date of Birth: _____

Print Parent or Guardian Name: _____

Signature: _____ Date: _____

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CANCELLATION AND NO SHOW POLICY

Thank you for trusting your health care to Centennial OB/GYN, P.A. When you have an appointment with our providers, we dedicate that time to focus on you and your medical care and concerns. Should you need to cancel or reschedule an appointment, we ask that you give us adequate notice to enable us to utilize that time for other patients in need of our care. We will pro-actively remind you of your appointment via text and/or phone call.

Cancellations / Rescheduled Appointments

We understand that there are a variety of reasons which can cause you to cancel or reschedule. We ask that you call us as soon as possible to do so. Out of courtesy to other patients' medical needs, please call us at least 48 hours (2 business days) prior to your appointment to cancel or reschedule.

No Show Appointments

A No-Show appointment is one which is missed without cancelling or rescheduling.

NO SHOW FEES

All fees are charged directly to the patient, not the insurance company, and must be paid before another visit will be scheduled. Fees will be assessed if you do not call to cancel or reschedule at least 1 business day in advance*.

Office Appointments – $25.

Diagnostic Appointments - (i.e. ultrasound, NST) - $50.

Procedure Appointments – (i.e. EMB, EndoSee, IUD, Nexplanon, etc) - $75.

Surgery Appointments – * $100 if not cancelled or rescheduled at least 72 hours (3 business days) prior to your appointed time. This applies to both in-office and hospital surgical procedures.

I HAVE READ AND UNDERSTAND THE CANCELLATION AND NO SHOW POLICY. I AGREE TO THE TERMS.

Signature (Patient / Legal Guardian) _____ Relationship to Patient _____

Printed Name _____ Date _____

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