

2019 Financial Policy Statement

Welcome to Fairfax OB-GYN Associates, Inc. We are pleased you have chosen our practice for your medical care. We ask that you **carefully read** and sign the following statement.

We must emphasize that as your medical care provider, our relationship is with you and not your insurance carrier. As a courtesy to you, we will file your claim with your insurance company. However, you are the sole responsible party for all charges incurred and guarantee payment thereof. Benefit eligibility obtained from your insurance company is for informational purposes only and not a guarantee of payment.

If our office contracts with your insurance company, we will accept assignment of payment in accordance with your insurance coverage. You will be responsible for your payment portion (copayments/deductibles) at the time of service. All co-payments, co-insurance and deductibles are due and payable at the time services are rendered. If we do not have a contract with your insurance company, you are responsible for 100% of the payment at the time services are rendered.

You may receive a separate bill from the laboratory for analyzing your pap smear, biopsies, or other blood work for any financial responsibility you may have outside of your insurance coverage (including copayments or deductibles), or if you do not have insurance. Any questions about these bills should be directed to the lab or to your insurer. Our office staff cannot provide information on behalf of the laboratory or your insurer regarding coverage or billing issues.

All balances become your responsibility when the account reaches 45 days from the date of service. Failure to provide necessary referrals and/or authorizations or failure to provide current, accurate billing information may result in all charges for services becoming the sole responsibility of the patient/responsible party. You are expected to understand your benefits coverage and responsibilities. This includes obtaining any referrals and/or authorizations which your insurance company might require before care is provided.

All account balances still owed to Fairfax OB-GYN Associates, Inc. when the account reaches 75 days from the date of service will be referred to an outside agency for collection. Accounts referred to a collection agency will incur a fee of 28% of the principal balance, to cover collection/attorney fees and interest.

In consideration of the services performed by Fairfax OB-GYN Associates, Inc. you agree to abide by the terms of this Financial Statement.

Patient or Responsible Party Signature

Date

I, _____ hereby authorize Fairfax OB-GYN Associates, Inc. to apply for benefits on my behalf for services rendered.

I certify that the information I have provided is correct. I authorize the release of any necessary information, including medical information for this or any related claim to the health insurance I have provided. Should collection action become necessary, I further authorize the release of demographic information including cell phone numbers to outside agency to facilitate collection of my debt. I permit a copy of the authorization to be used in place of the original. I may revoke this authorization at any time in writing.

Patient Signature

Date

Witness

Date