Westmoreland Obstetric & Gynecologic Associates, SC

Scott Logan, MD Kelley London, MD Adam Cohan, MD

FINANCIAL PAYMENT POLICY

The purpose of this form allows Westmoreland Obstetrics & Gynecologic Associates, SC to treat you, bill any insurances you may have, share information with other health care offices/facilities, and to collect on your account.

REGARDING INSURANCE: Our office participates with Medicare and many managed care insurance companies. Should your insurance coverage be with one or more of these companies, we will bill your insurance company along the guidelines of our contract. However, co-payments, co-insurances, deductibles, and non-covered services that have not been satisfied, are the responsibility of the patient and payment is expected at the time services are rendered. If you have an insurance with which we do not participate, we ask that payment be made at the time services are rendered and your insurance company will reimburse to you any amount due. As a courtesy to our patients, we will submit a claim to your insurance company.

SPECIAL NEEDS: There are times when making a payment can be a financial hardship. It may be necessary to set up a payment plan for a patient who cannot comply with our financial policy. If you are in need of special payment arrangements, please advise our staff prior to your visit. Co-pays are exempt from this because your insurance requires you to pay your co-pay at the time services are rendered.

I authorize treatment by the providers of Westmoreland Obstetric & Gynecologic Associates, SC. I also authorize the release of any information requested by insurance companies or liable third parties and I assign any insurance benefits to Westmoreland Obstetric & Gynecologic Associates, SC. If the correct insurance information is not given or the proper referral is not obtained, then the patient will be responsible for the balance in full.

I acknowledge that I have received a copy of Westmoreland Obstetric & Gynecologic Associates, SC Notice of Privacy Practices. I hereby understand the financial policy of this office. I guarantee payment of all charges incurred for the account of the patient below. I further agree to pay any incurred Collection fees, Attorney fees and Court Costs related to collection on my account balance.

- **THE PATIENTS' ENTIRE SOCIAL SECURITY NUMBER WILL BE REQUIRED BEFORE BEING SEEN AS THE OFFICE IS EXTENDING CREDIT FOR SERVICES PERFORMED UNTIL WE ARE PAID BY THE INSURANCE COMPANY.**
- **THE FEE FOR A RETURNED CHECK IS $25.00.**
- **THERE WILL BE A $ 25.00 FEE FOR ANY APPOINTMENTS YOU DO NOT KEEP WITHOUT AT LEAST A 24 HOUR NOTICE OF CANCELLATION.**
- **CO-PAYS ARE DUE IN FULL AT THE TIME OF SERVICE.**
- **INSURANCE INFORMATION SUBMITTED TO US PAST THE TIMELY FILING DATE, WILL BE YOUR FULL FINANCIAL RESPONSIBILITY.**
- **CALLS REGARDING PRESCRIPTION REFILLS WILL <u>ONLY</u> BE ADDRESSED DURING OFFICE HOURS. THE CHARGE FOR PRESCRIPTIONS THAT ARE NOT HANDLED DURING OFFICE HOURS VIA PHONE IS $50.00.**
- **IF YOU HAVE A PROBLEM THAT IS HANDLED VIA A PHONE CONSULTATION INSTEAD OF AN OFFICE VISIT, YOU WILL BE CHARGED BASED ON THE TIME SPENT WITH THE DOCTOR OR NURSE WHO TALKS TO YOU. SOME INSURANCE PLANS DO NOT COVER PHONE CONSULTATIONS, AND SO YOU MAY BE BILLED FOR THE COST.**

_____ _____

Patient or Guardian Signature (Must be 18 or older to sign) | Date

_____ _____

Please print patient name | Patient Social Security Number

_____ _____

Please print Guardian's name | Guardian's Social Security Number