

**BEND OBSTETRICS & GYNECOLOGY, LLC
FINANCIAL & ADMINISTRATIVE POLICIES**

RECEIPT OF PRIVACY PRACTICES

- I acknowledge that I have received or been allowed to view a copy of Bend OB/GYN's Notice of Privacy Practices as required by HIPPA. This notice describes how Bend OB/GYN may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

Initial _____

PATIENT PAYMENT POLICY

- It is the policy of Bend OB/GYN to collect all payments and co-payments due from patients at the time of service.
- If you are being seen for a procedure, a pre-operative appointment or are starting obstetric care our office will contact your insurance carrier to verify your insurance benefits. The determination of your financial responsibility will be made according to the contractual agreement between Bend Obstetrics & Gynecology, LLC and your insurance company.
- Our Benefits Coordinator will review your benefits with you and explain what your financial obligation to Bend OB/GYN will be. All benefits estimated to be the patient portion will need to be paid prior to procedures, surgeries and deliveries.
- If your insurance claim denies payment due to incorrect personal information or incorrect insurance information that you have provided, you will be billed and payment in full will be due immediately.
- If your account or any account that you are responsible for is sent to a collection agency for non-payment, you will face possible dismissal from care, which includes all providers at Bend OB/GYN.
- It is your responsibility to know the services covered by your insurance and if your insurance does not cover these services, you will be responsible for payment.
- If you do not have insurance, you will be asked to pay at the time of service and will be given a 10% discount.
- A photo ID will be requested from all patients.
- New patients who do not supply their insurance card must pay in full at the time of service.
- Most labs collected in this office will need to be sent to an outside lab for testing and those charges are separate from the charges incurred in this office.
- If you are required to have a referral or authorization for office services, it is your responsibility to get one.

Initial _____

FLEX SPENDING PLANS/REIMBURSEMENT PLANS

- If you have a Flex Spending Plan or other type of Reimbursement Plan, you will be required to pay the portion which Bend OB/GYN estimates is the patient's responsibility prior to any procedure, surgery or delivery and will be provided with a receipt to use for reimbursement from you plan. If your plan provides you with a "credit card" for payments, we will be happy to accept this form of payment.

Initial _____

CANCELLATION POLICY

- Our clinic requires a 24 hour cancellation notice.
- No shows and cancellations without a 24-hour notice may receive a \$25.00 charge. This is the patient's responsibility and is not reimbursed by insurance.
- If a patient repeatedly misses or cancels an appointment, the patient may be dismissed from the entire practice.

Initial _____

PREVENTIVE CARE

- Your health insurance plan may not provide coverage for preventive service. It is important that you contact your insurance provider to determine if your plan offers benefits for this service and what their scheduling guidelines.

Initial _____

RETURNED CHECK CHARGE

- Bend OB/GYN will charge the patient account \$25.00 for any returned checks to cover the cost of the associated bank charges.

Initial _____

PERSONAL INFORMATION VERIFICATION

- It is our policy to verify your demographic and insurance information **at every visit** to help insure that your insurance claims are processed quickly and correctly. Although it may seem unnecessary to you at the time, especially if you have been seen recently, it is extremely important to our billing process. Please bring your insurance card with you **EVERY VISIT.**

Initial _____

I have read and understand the above policies.

Patient Signature: _____ Date: _____

PRINTED NAME