GynOb associates

373 New Boston Rd. Fall River, MA 02720
Tel: (508) 679-0911 - Fax: (508) 536-0310

Patient Name: _____ Date of Birth: _____

Patient Financial Obligations

1. Co-payments must be paid at the time of your visit. We accept cash, checks, and credit card payments.
2. There will be a $25 fee charged for all checks returned to us due to insufficient funds.
3. You are responsible for any charges incurred as a result of your visit.
4. Your claim will be processed through your insurance company(ies) provided that we have ALL the accurate and complete information.
5. It is your responsibility to obtain a referral from your primary care physician prior to your visit if your insurance requires one.
6. If you do not provide us with a referral prior to your visit, we reserve the right to reschedule your appointment.
7. We will assist you wit obtaining pre-authorizations for any scheduled surgeries.
8. If your insurance company fails to pay your bill within 90 days, the bill will be transferred to you.
9. If you fail to make prior arrangements with us and your account balance extends beyond 90 days in arrears, your account will be turned over to a collection agency.
10. You are responsible for any treatment, supplies, etc., that your insurance does not cover.
11. If you have no insurance, payment is expected at the time of service.
12. Medicare is accepted, however a co-payment is required unless you have secondary insurance.
13. We participate in many managed care plans and will comply wit our contractual obligations.
14. A minimal fee of $5.00 is charged for completing any disability forms.
15. Adult patients are responsible for full payment of their accounts.
16. Patients under the age of eighteen (18) will not be seen unless accompanied by a parent/guardian, or unless we receive a signed authorization from the parent/guardian, which allows the physician to provide medical treatment.
17. You are expected to keep all scheduled appointments. Failure to do so without providing us 48-hour notification will result in a charge of $50 for missed appointments.

Please ask if you have any questions about your financial obligations.

I have read and understand my Patient Financial Obligations. By signing below, I agree to comply with this policy.

_____ _____

(Signature of Patient) (Date)