MID-ATLANTIC OBGYN
physicians & midwives

Financial Policy Statement

Welcome to Mid-Atlantic OB-GYN. We are pleased you have chosen our practice for your medical care. We ask that you carefully read and sign this Financial Policy Statement. 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 solely responsible for all charges and payment to Mid-Atlantic OB-GYN. Benefit eligibility obtained from your insurance company is for informational purposes only and not a guarantee of payment. If we are contracted with your insurance company, we will accept assignment. You will be responsible for your payment portion at the time of service. After 45 days from the date of service, you agree to pay any unpaid amounts that are not paid by your insurance. It is your responsibility to provide necessary referrals and/or authorizations. 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 co-pays, co-insurance and deductibles are due and payable at the time services are rendered. If we do not have a contractual obligation with your insurance company, you are responsible for 100% of the payment at the time services are rendered.

*If your account balance is under $300.00 we will automatically deduct the monies owed with the credit card/debit card on file.

Any amounts owed to Mid-Atlantic OB-GYN after, 90 days from the date of service will be referred to an outside agency and/or attorney for collection. You agree to pay Mid-Atlantic OB-GYN interest at the rate of 18% per annum from the date of service on any amounts that are not paid after 45 days from the date of service. You agree to pay Mid-Atlantic OB-GYN all costs of collection, including but not limited to all collection costs, attorneys' fees, court costs, and expert costs from the date your account is turned over to an outside agency or to an attorney for collection.

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

Patient Signature _____ Date_____

Printed Name _____

Guarantor Signature _____ Date_____

Printed Name _____

Authorization

I, _____ hereby authorize Mid-Atlantic OB-GYN, 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_____

Printed Name _____

I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

Patient Signature _____ Date_____

Printed Name_____