

Summit Ob Gyn LLC
Financial Policy

We are dedicated to providing the best care for you, and want you to completely understand our financial policies.

By executing this agreement you are agreeing to pay for all services that are received.

Contracted Insurance: If we are contracted with your insurance company, we must follow our contract and their requirements. If you have a co-pay it is your responsibility to pay at the time of visit. If the insurance company requires pre-authorization or a referral to come to our office you are required to obtain one prior to your visit.

Your insurance policy is a contract between you and the insurance company. As a service to you we submit the claims on your behalf, you are assigning your benefits to the doctor, in other words you have agreed to have the insurance company pay the doctor directly. If the insurance denies payment you are responsible for the bill. If the insurance determines a service is "not covered" you are responsible for the complete charge.

If you have no insurance coverage or your policy is not in effect at the time of visit, the service must be paid in full.

Payment Options: Payment is due the time of visit. You have the option of paying by Cash, Credit, or Debit. We accept Visa, MasterCard, American Express, and Discover.

Monthly Statements: If you have a balance on your account, we will send you a monthly statement. It will show any previous balances, new charges, and any payments that have been made to your account.

Past Due Accounts: If your account becomes past due, we will take the necessary steps to collect this debt. If we send your account to collection you agree to pay all of the collection costs which are incurred.

Transferring of Records: You will need to request in writing and pay a reasonable copying fee if you want to have a copy of your record, or have your records sent to another doctor or organization. You authorize us to include all relative information, including your payment history. If you are requesting your information to us you are authorizing us to receive all relative information, and payment history.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions herein.

Name of Patient

Responsible Party (If not the patient)

Signature

Date