BELLINGHAM
OB/GYN
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BellinghamObGyn.com

BELLINGHAM OB/GYN FINANCIAL AGREEMENT

Thank you for choosing Bellingham Ob/Gyn as your women's healthcare provider. It is our goal to provide exemplary obstetrical and gynecological care. This document outlines our practices financial policies. Your understanding of this information is important. We thank you in advance for taking the time to review these polices. Please feel free to discuss any concerns or questions you may have with our billing staff.

FINANCIAL RESPONSIBILITY

I understand that in consideration of the services provided to the patient, I am directly and primarily responsible to pay the amount of all charges incurred for services and procedures rendered at Bellingham Ob/Gyn. I am responsible for any applicable deductible, co-insurance or co-payments prior to the provision of services. For surgery and pregnancy, Bellingham Ob/Gyn will provide me with an estimate of my financial responsibility and the date by which this amount must be paid in full. I understand that due to the individual needs of each treatment, procedure or pregnancy, this fee is only an estimate. In the event my care exceeds the amount of the estimate, I will be financially responsible for the balance. I further understand that such payment is not contingent on any insurance, settlement or judgment payment.

RESPONSIBILITY TO PROVIDE PROOF OF INSURANCE

I understand that it is **my responsibility** to provide Bellingham Ob/Gyn with a copy of my **current insurance** card and **to obtain a referral** from my Primary Care Physician (if required by my insurance). Bellingham Ob/Gyn is not obligated to see patients without a valid referral. If I do not have insurance, I will be considered a Private Pay (or Self Pay) patient and I am financially responsible for the total amount of the services provided. **I will notify Bellingham Ob/Gyn immediately upon any change in my insurance**

INSURANCE WAIVER, NON-COVERED SERVICES WAIVER , OUTSIDE LAB SERVICES

I understand that if I do not have a copy of a current insurance card and valid referral, if required, Bellingham Ob/Gyn is not obligated to see me, but if I still wish to be seen, I can be seen as a "Private Pay" patient. I agree that neither Bellingham Ob/Gyn nor I will file a claim for the visit. I will be required to pay the total cost of the visit in advance. In addition, there may be a service I desire, suggested or provided that is not covered under my insurance plan ("Non-Covered Services"); I understand I must pay for "Non-Covered" services. If feasible, a waiver will be completed for each "Private Pay" visit or "Non-Covered Service." I understand services sent to an outside lab are billed to my insurance or me by the lab and I will receive a separate invoice from the lab.

ANNUAL EXAMS

I understand that it is my responsibility to familiarize myself with any restrictions my insurance has on preventative services and that I am responsible for payment, if the exam or portion of the exam is not covered by my insurance.

Annual exams do not typically include problems I may be having – as problem visits may require longer time. If I am experiencing problems, the office may be required to reschedule another visit to address these concerns, or bill an office visit fee in addition to my annual exam.

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PAYMENTS AND FEES

Bellingham Ob/Gyn accepts payments in: Cash, Check, Debit and Credit Cards.

I understand additional charges are applied to my account for any returned checks used to pay on my account, for the cost of certified letters sent to me for collection on my account and any collection agency or legal fees associated with the attempt to collect payment on my account. I may also be charged if I do not cancel my scheduled appointment, for not paying my co-pay and/or co-insurance or patient responsibility including deductible at the time of service, for telephone management services, for educational materials, for payment agreements which extend beyond 60 days, and for other administrative expenses not covered by my insurance plan.

CONSENT TO TREAT, ASSIGNEMENT OF BENEFITS

I hereby consent and authorize the performance of all appropriate procedures and courses of treatment, the administration of all anesthetics, and any and all medications which in the judgment of my provider may be considered necessary or advisable for my diagnosis and/or treatment. In addition, I authorize Bellingham Ob/Gyn to release medical information necessary to obtain payment from my insurance carrier and assign all payments and/or insurance benefits paid on my behalf directly to Bellingham Ob/Gyn.

SIGNATURE

BY SIGNING THIS AGREEMENT, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS

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Patient Signature Date