
## *FINANCIAL POLICY*

As we enter this doctor-patient relationship, we agree to provide quality healthcare care at a fair and reasonable price, and you in turn, agree it is your obligation to be prepared to pay at the time of service and to understand the benefits of your insurance. We want to explain our financial policy to you so there are no unpleasant surprises.

- **Co-payments, deductibles and/or coinsurance are due at the time of service.** We accept Cash, Personal Check, MasterCard, Visa, and Discover. If you are not prepared to pay the required amount, we are required to reschedule the appointment. The estimated financial responsibility for scheduled services will be due ***prior*** to these services being provided. Any remaining balance after your health plan pays will be due upon receipt of a statement. If insurance coverage cannot be verified prior to the appointment, the account will be notated as private pay and payment will be due in full. *Account balances over 90 days with no payment activity will be reported to the credit bureau(s).* ***Initial*** _____

- **20% Discount will be given to patients that are self pay and pay the bill at time of service.**
  *No discount will apply if bill is not paid in full at time of service.* ***Initial*** _____

- **Your insurance policy is a contract between you and your insurer. It is your responsibility to know what your policy covers and what it does not although we will help you get the most out of your benefits.** We cannot quote your benefits. Any item deemed "non-covered" by your insurance carrier will be your financial responsibility. We do not accept 'usual and customary' payments. Any disputes about payment must be resolved between you and your insurer. This also includes lab designation and payment disputes. You are responsible for ensuring a properly dated referral and/or authorization if required by your insurer for services being provided. It is your responsibility to make certain you have subsequent authorizations during ongoing treatment. You are also responsible for payment if your claim denies for lack of referral/authorization. ***Initial*** _____

- As a courtesy to you, we will file primary participating insurance for you with proper assignment within 3 business days of your appointment. Insurance will not be accepted if presented after 3 business days from the date of your appointment. Any additional policies will be yours to file with your receipt from our office. Please bring your primary insurance card with you to <u>every</u> visit and provide the front desk with any updated information at check-in. I understand that all remaining balances are my responsibility to satisfy prior to additional services being rendered. ***Initial*** _____

- This office is not party to legal disputes/agreements. The financial responsibility rests with the patient. ***Initial*** _____

- A **$25.00** fee will be assessed for all **returned checks**. ***Initial*** _____

- Payments & credits are applied to the oldest charges first, except for insurance payments, which are applied to the corresponding dates of service. Refunds over $50 will be provided within 30 days from the date all outstanding claims are satisfied. Any credit balance less than $50 will be available and processed upon request of the patient. ***Initial*** _____

- **Transferring of Records** requires a written request and a $25 fee prior to any information being released. Occasionally we will need to refer you to another specialist. We offer recommendations Based on our experience with the specialist. The specialist may or may not be an in-network provider with your insurance carrier. It is the patients' responsibility to contact your insurance carrier to find out if that physician is in-network. If they are not you can: 1) choose to see a physician in-network according to your carrier or 2) see the physician we recommend out-of-network. ***Initial*** _____

- **Laboratory Test** - When you have a pap smear or any type of blood work done, we will send the specimen to an outside lab. We utilize *Clinical Pathology Laboratories (CPL) unless otherwise specified by the patient.* Since we do send all lab specimens to an outside lab we do not charge for the actual test; the lab will bill you separately if your insurance does not cover them. ***Initial*** _____

- **Prescription refill requests** will be handled within 24 hours of a request during regular office hours. No prescription refills will be handled after regular office hours or on the weekend. ***Initial*** _____

- A **$25.00** fee will be assessed for **FMLA** and disability forms. ***Initial*** _____

- A **$25.00** fee will be assessed for any **"No Show"** appointments or cancellations without a 24-hr notice. ***Initial*** _____

- **Medicaid is my current insurance provider. Yes _____ No _____**

  **If yes**, I understand that in the opinion of Cornerstone Ob-Gyn, the services or items that I have requested or have been recommended to me may not be a covered benefit under my current Texas Medicaid program. I understand that the HHSC or its health insuring agent determines the coverage or medical necessity of the services or items that I request and receive. I also understand that I am responsible for payment of the services or items I request and receive if these services are not covered under my plan. **Initial _____**

- **In the event my insurance changes, it is my responsibility to notify Cornerstone OBGyn within ten (10) days. If the office is not notified, I am responsible for filing my own insurance claims and am financially responsible for any denied claims**. **Initial _____**

I have read and understand the Practice's financial policy and I agree to be bound by its terms. I understand that if I do not take care of my financial responsibility, I can and will be denied an appointment in the future. I also understand and agree that such terms may be amended by the Practice at any time.

_____ _____
Responsible Party Printed Name (Must be 18 or over) Date

_____ _____
Responsible Party Signature (Must be 18 or over) Date

I authorize the office staff and/or Jo Choudhry MD, Kathryn Anger, MD, Blanca Duncan, MD, Kendra Bookout, MD to verbally release any or all of my medical information to the following individuals:

Name_____ Spouse, Parent, Other_____

I understand that this is an appropriate request that I can make in our patient physician relationship and follows the guidelines if medical confidentiality.

Patient Signature_____ Date_____

In the event that I am referred to another specialist by the office of Jo Choudhry MD, Kathryn Anger MD, Blanca Duncan, MD or Kendra Bookout, MD, I authorize release of any or all of my medical records by Jo Choudhry MD, Kathryn Anger MD, Blanca Duncan MD or Kendra Bookout MD.

Patient Signature_____ Date_____