DOXOLOGY
HEALTH & FERTILITY

Statement of Financial Policy

Thank you for choosing us as your health care provider. The following is a statement of our Financial Policy which we require you to read and sign prior to your first visit.

FULL PAYMENT IS DUE AT THE TIME OF SERVICES UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE.

Regarding Insurance

We will accept assignment of insurance benefits. Assignment simply means that we will bill your insurance and after receiving payment from them, bill you for the balance. We participate with several insurance plans but it is your responsibility to check with your insurance company to be sure that we are on their list of providers. If you choose to come to our practice and we are not on your insurance company's panel, you will be responsible for the difference between what the insurance company pays and our charges. Your insurance company has the current list of participating physicians. **It is your responsibility to ensure that your plan covers the benefits and procedures you are seeking. If a procedure is a non-covered service in your plan, you will be responsible. Before any procedure, it is best to double check your coverage with your insurance company.**

Your co-payment is to be paid at the time of service. Failure to pay your co-payment at the time of service will result in a rebilling fee of $15.00, or you may be required to reschedule your appointment. The balance is your responsibility whether your insurance company pays or not. We reserve the right to see your insurance card with each visit.

There is a charge for problems evaluated during an annual exam. You may be responsible for two co-payments for that date of service. You may also be required to pay a deposit on a scheduled surgery at your pre-op appointment. Our office will verify insurance benefits and determine the deposit based on your deductible and coinsurance amounts.

Your insurance policy is a contract between you and your insurance company. If your insurance company has not paid your account in full within 60 days, the balance will automatically be transferred to your account. Please be aware that some, perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurance. You will receive a statement each month even though an insurance claim is pending.

Forms Completion

In some cases, we will need to charge for the completion of forms. You will be charged for forms such as short term and temporary disability. Your insurance does not pay the office to complete these forms. If you have questions, please ask a receptionist about the associated charges.

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our specialty. You are responsible for payment regardless of your insurance company's determination of usual and customary rates.

Adult Patients
Adult patients are responsible for full payment at time of services, unless other arrangements have been made prior to visit.

Minor Patients
The adult accompanying a minor and the parents (or guardian of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, Visa, MasterCard, or payment by cash or check at the time of service.

Missed Appointments
Our policy is to charge $25.00 for missed appointments not canceled more than 24 hours in advance. This cannot be billed to your insurance and is your personal responsibility. This amount must be paid prior to scheduling another appointment.

Self Pay Patients
All patients are expected to pay for services at the time that they are received. However, some medical procedures are expensive and unexpected, and as such, may require time for payment. Payment over time is not permitted unless specifically authorized by a member of the business office staff. Self pay patients who have no balance on their account will be given a same-day discount for all payments made the date of service. Patients failing to pay at the time of service will not be eligible for prompt payment discounts.

Bankruptcy
If this office has been included in your bankruptcy, you will no longer be a patient with the practice.

Termination
We use a collection agency for all accounts that we are unsuccessful in collecting. In that event, you will be sent a letter terminating our services to you and/or your family from this office. You will be given a 30-day period to establish yourself with a new doctor. During those 30 days, you can be seen by our staff doctor for emergencies only.

Thank you for reviewing our Financial Policy. Please let us know if you have any questions or concerns.

I, _____(print name), agree to the financial policy of Doxology Health and Fertility on _____ (date). My signature verifies that I understand that the responsibility for payment for Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a rebilling fee will be added to any balance over 30 days.

_____ _____

Signature of Responsible Party **Date**