

## BILLING AND OFFICE POLICIES

Welcome and thank you for choosing OB-GYN Associates of Ithaca for your care. Optimal health for women is achieved when we work as a team. We will do everything in our ability to help guide you through the physical and emotional issues that may come up; however, you are ultimately the person responsible for your own health and wellness. Listed below are some billing and office guidelines to help us work with you in the best possible way.

1. I understand that any co-pays that I owe are expected at the time of my visit. I am aware that it is my responsibility to check if tests or procedures offered are covered by my insurance company.
2. I understand that if I am unable to keep an appointment, OB-GYN Associates requires a phone call 24 hours in advance. Failing to do so will result in a \$30 no show fee. I am also aware that if I miss 3 appointments without giving 24 hours notice I may be dismissed from the practice. (Please note that we understand extenuating circumstances occur, in which case please call us as soon as possible.)
3. I understand that if I do not have insurance, payment is due at the time of service unless other arrangements have been made in advance with the billing department. I understand that any unpaid personal balances over 28 days old are subject to a monthly finance charge of \$15.00. OB-GYN Associates is happy to help with payment arrangements for personal balances if needed. (Please call the billing department for payment arrangements.)
4. I understand that OB-GYN Associates offers a sliding fee discount program to those who qualify. (Please call the billing department or visit the website for details.)
5. I understand that as a courtesy to me, OB-GYN Associates will bill my insurance for services rendered regardless of participation status. If the office does not participate with my insurance I understand that I am responsible for the balance and will be billed accordingly. I will refer to my insurance company for confirmation of participation status and coverage benefits.
6. I understand that OB-GYN Associates is committed to maintaining an atmosphere of mutual respect in the office. I should expect to be treated with sensitivity and courtesy during all aspects of my care. I will inform the office if I feel that this has not been my experience. I also understand that OB-GYN Associates also expects the same from me. I am aware that yelling at or threatening any member of the office staff will result in dismissal from the practice.
7. I understand that at each visit I will be asked to verify my information including address, phone number and insurance information. This may seem repetitive, however in order to receive the best care, it is necessary. If there have been any changes to my information, I will make every effort to inform the office immediately.
8. I understand that while my scheduled appointments are always with one of the providers affiliated with OB-GYN Associates, there is a possibility of another doctor or hospitalist not associated with OB-GYN Associates being on call if I need medical attention after office hours. This may include hospital care and or delivery.
9. I understand that there will be routine testing, including testing of blood and urine while under the care of OB-GYN Associates of Ithaca.
10. I understand that if I fail to present my current insurance information to the office at the time of my appointment, I will need to do so within the next 10 days. If this is not done, I am aware that I will be financially responsible for the bill. Methods for providing OB-GYN Associates with current insurance information include, but are not limited to:
  - Call 607-266-7800 with most recent insurance information.
  - Fax an enlarged copy of insurance card to 607-216-0093.
  - Come into the office with insurance card.

I authorize OB-GYN Associates of Ithaca to bill my insurance and to release any information to my insurance necessary to settle a claim on my behalf for services rendered while I am a patient of OB-GYN Associates of Ithaca. I also authorize payment to be made directly to OB-GYN Associates of Ithaca. If my insurance denies payment for certain services, I agree to be personally and fully responsible for payment. By signing the bottom of this page, I agree to abide by the guidelines set forth above.

Signature: \_\_\_\_\_ Printed name: \_\_\_\_\_ Date: \_\_\_\_\_