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GROUP FINANCIAL POLICY FOR OBSTETRIC CARE

Please be advised of Advanced Obstetrics & Gynecology of Lake County, LLC policy concerning your pregnancy and insurance coverage.

Please initial each line below:

_____ ***To protect my identity and for billing purposes I will provide the organization with my photo identification, original health insurance card and a copy of the credit card*** (only for credit card payments). Copies will be kept in your electronic file. It is my responsibility to notify our office of any patient information changes (i.e. address, name, insurance information, etc.).

_____ **Insurance Information**- Is required that I disclose all insurance information including primary and secondary insurance. Failure to provide complete insurance information may result in my responsibility for the entire bill. It is my responsibility to know my insurance benefits as it may not cover all of the services provided to me.

_____ **Insurance Changes** - It is my responsibility to notify Advanced OB-GYN office of any information changes.

_____ **Delivery Charges**- Some insurance companies apply part of the delivery charges as co-insurance and/or deductible. This balance is considered part of the total reimbursement to the doctor, and will be my responsibility.

_____ **Prenatal Care Global Billing**- prenatal care are is billed globally and will be billed at the end of my pregnancy, after delivery. Prenatal care includes my routine office visits and delivery charges.

_____ Additional studies ordered by providers during my pregnancy, such as ultrasounds or non-stress tests. Will be billed to my insurance at the time of the service, and are not included in the global prenatal care fee.

_____ If I'm seen for any problem or condition unrelated to my pregnancy, Advanced OB-GYN are required to bill for the office visit. I may be responsible for co-pays and/or additional fees for these services, which will be determined by my contract with my insurance company.

_____**Cancellation of Appointments**- Advanced OB/GYN requires 24-hour notice of appointment cancellation. There is a fee of $25 for appointments that are missed and not previously cancelled.

_____**Returned Checks**- The charge for a returned check is $25 payable in cash or by credit card. This will be applied to your account in addition to the insufficient funds amount.

_____**Outstanding Balance Policy**- All accounts remain current. In the event that a patient balance remains outstanding and no resolution can be made, my account may be sent to a collection agency and/or I may be discharged from the Practice.

_____**Laboratory Fees**- Most laboratory charges, such as blood work, PAP and pathology tests, ordered through our office are billed directly to your insurance by lab company. If you receive a statement from one of laboratories, we request that you contact them directly to resolve any billing questions.

This financial policy helps the office provide quality care to our valued patients. If you have any questions or need clarification of any of the above policies, please feel free to contact us.

I have read and understand the above information and agree to comply with these financial policies.

Print Patient Name: _____ Date of Birth:_____

Patient Signature: _____ Today's Date: _____