Truesdale OB/GYN

Patient Name: _____ Date of Birth: _____

Patient Financial Obligations

1. Co-payments must be paid at the time of your visit. We accept cash, checks, and credit card payments.
2. There will be a $25 fee charged for all checks returned to us due to insufficient funds.
3. Your claim will be processed through your insurance company(ies) provided that we have all the accurate and complete information.
4. You are responsible for any charges incurred as a result of your visit that your insurance does not cover.
5. If you have no insurance, payment is expected at the time of service.
6. It is your responsibility to obtain a referral from your primary care physician prior to your visit if your insurance requires one.
7. If you do not provide us with a referral prior to your visit, we reserve the right to reschedule your appointment.
8. If you fail to make prior arrangements with us and your account balance extends beyond 90 days, your account will be turned over to an outside collection agency that may report you to the credit bureau.
9. A minimal fee of $20.00 is charged for completing any disability forms.
10. You will be required to make payment arrangements for any past due balances.
11. If you fail to cancel a scheduled ultrasound appointment at least 24 hours prior to your appointment time, you will be charged a $25.00 fee.
12. If we do not receive payment for any past due balances within 30 days a $5.00 fee will be imposed.

Please ask if you have any questions about your financial obligations.

I have read and understand The Patient Financial Obligations Policy. By signing below, I agree to comply with this policy.

_____ _____

(Signature of Patient) (Date)