FINANCIAL POLICY

Payment of charges/and or co-payments is due at the time service is rendered. As a courtesy we will file your claim to insurance carriers with who are participating providers. **We do not bill secondary insurance carriers**. If you have an insurance carrier with whom we are non-contracted, you will be responsible for payment in full at the time services are rendered. We will provide you with itemized receipt to submit to your insurance carrier. In the event of an emergency hospitalization or services, we will submit the charges to your insurance carrier as a courtesy to you. Any deductible and/or co-insurance amounts will be your responsibility. Any past due balances over 90 days will be submitted to a collection agency, unless other arrangements have been made.

On elective procedures we will contact your insurance carrier to determine your financial responsibility. All deductibles and/or coinsurance amounts will be collected prior to the date of your procedure. Please note: this is an estimate only and is subject to change after the insurance carrier has processed the claim.

WE ARE NOT PROVIDERS FOR MEDICARE OR MEDICAID

PRIOR AUTHORIZATION

If you have an insurance carrier that requires prior authorization in order to be seen in our office, it is your responsibility to obtain authorization. Failure to provide authorization may result in your appointment being rescheduled or higher out of pocket expenses.

AUTHORIZATION TO RELEASE INFORMATION

Per HIPAA guidelines, please list any family members or significant others that we may release any of your patient information to:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Please note: it is your responsibility to notify us of any changes to this list.

NOTICE OF PRIVACY PRACTICES

I have received the Notice of Privacy Practices.

_____ _____

Signature Date

I hereby give consent to Van Dyke Gynecology. to provide the necessary treatment the assigned physician and I have discussed.

I am aware that payment is expected at the time service is rendered.

I authorize any physician examining and/or treating me to release to any third party (such as an insurance company or government agency) any medical information requested for use in determining claim for payment.

I authorize payment medical benefits to Van Dyke Gynecology.

I permit a copy of these authorizations and assignments to be used in place of this original, which is on file at the physician's office.

_____ _____

Signature Date