Highland GYNECOLOGY

Financial Policy

Thank you for selecting our practice for your gynecology needs. Our goal is to provide you with the highest quality of treatment and service. Your complete understanding of your financial responsibilities is an essential element of your care. If you have any questions about the following policy, please do not hesitate to ask our staff.

Effective January 1, 2021 all copays, deductibles and co-insurance are due at the time services rendered. **Please be aware that we collect an estimated payment on a few of these visits/procedures at the time of check out.** If after submitting an in-network claim, including secondary insurance and you have already met your deductible elsewhere and should your insurance pay any portion of or all charges, we will refund your payment upon receipt of your insurance payment. In the event your health plan determines a service to be "not covered", or if we do not have an authorization on file prior to the appointment or you do not inform us of an insurance change, you will be responsible for the complete charge at time services are rendered. We encourage our patients to understand their policy and to contact their insurance provider for clarification of benefits prior to services rendered.

You may receive a separate bill for laboratory or pathology services from an off-site lab for any tests your physician may order. Please discuss any billing errors or discrepancies with that laboratory.

Notice to parents with children under age 18 (when applicable):
In cases of divorce or separation, the parent authorizing treatment for a child will be the parent responsible for any charges. If a divorce decree requires the other parent to pay all or part of the costs, it is the authorizing parent's responsibility to collect from the other parent.

- Cancellation, missed appointments and late arrivals If we do not receive 24 hour notice there will be a $25.00 cancellation/no show fee billed. Patients with multiple cancellations or missed appointments also may be discharged from our practice. In an event that you are running late, please call our office. If you are more than 15 minutes late to your scheduled appointment, you may be asked to reschedule.
- Returned check fee There will be a $30.00 charge for all returned checks.
- Collection fee If your account is turned over to our collection agency, you will be responsible for the collection fee charged to us by the agency in addition to your outstanding balance.

We accept Cash, Checks, MasterCard, Visa, Discover, American Express and Venmo.

I have read and understand the financial policy, and I agree to be bound by its terms. I understand and agree that such terms may be amended in the future by the practice.

_____ _____
Printed Name of Patient Date

_____ _____
Signature of Patient or Responsible Party Date of Birth

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Optional

Credit Card Save on File

For your convenience and as an option, we kindly request that you leave a credit card on file which may be used to reduce your remaining balance after insurance pays. Due to the initial cost of IUDs and Nexplanon, we require all patients have a credit card on file prior to scheduling. Please complete and sign the following:

Credit Card Authorization

_____ (Initials) I authorize Highland Gynecology to bill my insurance for the services rendered today. Upon receipt of payment from my insurance company, I authorize Highland Gynecology to charge the below listed credit card in the amount of the remaining unpaid balance.

_____ (Initials) I understand that cosmetic procedures are not billed to my insurance. Should there be a remaining balance on cosmetic services, I authorize Highland Gynecology to charge the below listed credit card in the amount of the remaining unpaid balance.

_____ (Initials) An email will be sent to notify me of the additional charge to my credit card.

_____ _____

Patient Name Date of Birth

Credit Card Billing Address:

_____

Address line 1

_____

Address line 2

_____ _____

City, state, zip code Card holders Email address

_____

Best number to be reached

_____ _____ _____

Name as it appears on credit card last four numbers on credit card Credit card expiration date

_____ _____

Credit card holder authorizing signature Date

OFFICE USE ONLY:

Employee initials: _____

Date saved/ Sent to PAS: _____