McDowell Mountain Gynecology

Patient Notice of Financial Policy

Patient Name:_____DOB:_____

Our office is committed to providing you with the best possible health care, and we will be happy to discuss our professional fee with you. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, our Financial Policy or your financial responsibility. All patients must complete our patient information forms before seeing the doctor or nurse practitioner.

It is important that you understand that you are responsible for all charges that may occur during your visit. In addition to paying for any insurance co-payment at the time of your appointment, you may also be responsible for charges not covered by your insurance carrier. If your insurance carrier denies the medical claim, the patient and or responsible party is ultimately responsible for timely payment of the account. All patient balances are due within 30 days of notifications.

Communication with our patients regarding our financial policy is essential. If you have any special needs or concerns regarding this policy, please bring them to our attention. We are here to help you and to provide you with the best service.

Cancellation Fees

A **24 hour** notices is required if you are unable to keep your appointment. Missed appointments and appointments not cancelled within a 24 hour notice will be subject to a **fee of $70.00**. _____**Initial**

A **48 hour** notice is required if you are unable to keep your **Ultrasound Appointments and / or Urodynamic Appointments.** Missed ultrasound/ urodynamic appointments not cancelled within a 48 hour notice will be subject to a **fee of $ 50.00.** _____**Initial**

I have read the financial policy for the office and understand that I am ultimately responsible for all charges on my account. It is my financial responsibility to remit payment for any charges not covered by my insurance plan including, but not limited to co-insurance, co-payments, and deductibles. I understand that **co-payments for the office are due at the time of service**. I understand that **obtaining services immediately prior to bankruptcy is fraud.** I understand that once my account is put into collections, that I will be responsible for any additional charges to collect any and all unpaid balances, including but not limited to collection agency and attorney fees. I understand that if I refuse to pay my bill, a collection fee of 30% of the amount due will be charged to my account.

*** Any balance under $10.00 paid by Credit Card there will be surcharge of $2.50.**

_____ _____

Patient Signature (Required) **Date**

_____ _____

Employee Witness **Date**

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