

FINANCIAL POLICY



Patient Name: _____

Thank you for choosing Ideal Gynecology, LLC. Listed below are our financial policies. If you have any questions, please discuss them with the office manager.

Patient Responsibility

1. All co-payments are due at the time of the visit. Post-dated checks are not accepted.
2. Co-insurance and unmet deductibles are due prior to scheduled office visits, ultrasounds, surgeries, and procedures. Once benefits are verified and your financial responsibility calculated, you will be notified of the payment amount and due date.
3. You are ultimately responsible for payment of charges for services you receive from our office.
4. In accordance with your insurance member handbook, it is your responsibility to provide accurate insurance information and to present your insurance ID card at the time of your visit. If you do not have insurance or do not present a valid insurance card, you will be held responsible for payment at the time of service. We will provide you with a copy of our billing form so that you can obtain reimbursement from your insurance company.
5. It is your responsibility to ensure that our providers are in your insurance network.
6. If your plan requires a referral, it is your responsibility to obtain this prior to being seen by our provider.
7. It is your responsibility to notice the office of any change in your mailing address, email and phone number(s).
8. Cancellations for appointments and procedures must be received at least 24 hours prior to the scheduled appointment.

Cancellations for surgery must be received at least 5 days prior to the scheduled surgery date and time.

9. Payment is due for rendered services 7 days from receipt of your billing statement. Unpaid previous balance must be paid in full prior to any additional visit unless arrangements have been made with our financial counselor.

Fees

1. The returned check fee is \$30.00.
2. There will be an additional charge of 25% of the balance owed for any past due balance that is submitted to an outside agency for collections.
3. Patients who fail to keep and fail to cancel a scheduled appointment may be charged a \$50.00 No Show Fee. There is a \$200.00 cancellation fee for scheduled surgeries that are cancelled less than 5 business days from the date and time of surgery unless cancellation is due to insurance denial or medical necessity.
4. Medical records requests must be received in writing at least 72 hours prior to the date needed. Fees for medical records are set in accordance with allowable amounts as defined by the State of Georgia. Fees must be received prior to record delivery.
5. When a provider treats you via telephone, it is for emergencies only. Therefore, for routine problems that require history, diagnosis, and treatment (i.e., calling a prescription or refill into a pharmacy), the provider may bill a \$50 or \$75 service fee.
6. Like many other practices, in order for us to be able to provide administrative services, we charge an annual \$20.00 Administrative Fee. This fee covers specific administrative services, such as forms completion for family medical leave and disability, letters for insurance authorizations for brand or non-formulary drugs, letters for employers, school, health clubs, and any other administrative item not covered by insurance.

By my signature below, I acknowledge that I have read and understand this Financial Policy.

Patient Signature _____ Date _____