

OB/GYN Associates of Spokane PS

Financial Policy and Agreement

Welcome to OB/GYN Associates of Spokane PS and thank you for choosing our office for your women’s healthcare needs. Your wellness is important to us and we are committed to providing you with quality care and service. To help you understand our financial terms, we ask that you carefully read and sign this policy and agreement. A copy will be provided for your records. Representatives are available Monday-Friday 8:30 am to 5:00 pm to answer any questions.

**Patient Information:** At each visit, please provide us with any changes to your name, address, phone number and present your insurance card(s) for verification.

**Insurance:** We will bill your services to your insurance company. While every effort is made to collect from the insurance company, patients are responsible for denied charges, non-covered services and charges denied due to inaccurate or lack of current information. Please contact your insurance company for verification of coverage, preferred provider information, co-pay and referral requirements. Co-pays are due at the time of service. Balances after insurance processes are due in 30 days; if payment cannot be made in full, please call the bookkeeping dept at 623-1040 to discuss other payment options.

**Private pay:** If you have NO insurance, you will be required to pay \$50.00 at the time of service and the balance will be due in 30 days. If you pay in full at the time of service you will receive a 12% discount.

**Lab fees:** For billing questions on lab work, pap smears or pathology please call the facility on the statement you received.

**Surgical Services:** We will review insurance coverage and estimate charges prior to your surgical date when time permits and provide that information to you. Payment of your estimated charges are due prior to services being rendered unless financial arrangements are made in advance. Financing options are available through Care Credit and you may ask bookkeeping for details.

**Elective Services:** All elective services including infertility, elective surgical procedures and other services not covered by insurance are due at the time of service. Financing options are available through Care Credit, please ask the bookkeeper for details.

**Obstetric Services: Global maternity** (routine OB visits, delivery and post partum care) is billed at the time of delivery. You can expect to be billed a **maternity deposit of \$500.00**, the average co-insurance balance after insurance deductible has been met. This will appear on your statement as “OBEST” due by the 28<sup>th</sup> week of pregnancy. If you have an HSA, HRA or FLEX account, please notify the billing dept. All **problem visits, non-stress tests, ultrasounds and laboratory services** are billed at the time of service and due and payable after insurance processes.

**FMLA/Disability Forms:** A processing fee of \$10.00 will be charged for each set of forms completed.

**Insurance Assignment Authorization:** I request payment of authorized insurance benefits be made on my behalf to OB/GYN Associates of Spokane PS for medical services I receive. I authorize OB/GYN Associates and its agents to release my personal medical information to my insurance company and its agents for determination of benefits payable for related services.

OB/GYN Associates of Spokane PS strives to offer the very best medical care; therefore we have implemented these policies to continue to offer premium care to all of our patients.

I have read and understand the Financial Policy and Agreement.

\_\_\_\_\_  
Patient Signature Date

\_\_\_\_\_  
Print Patient Name Date of birth