

## Financial Policy Statement and Agreement Assignment of Benefits Acknowledgement

We would like to welcome you to our office. We are happy you have chosen us for your medical needs. Our goal is to provide you with the best possible care available and would like your visit to be a pleasant one. In order to meet this goal, we need your assistance and understanding of our patient policies. Our Financial policy is a necessary part of assuring the financial resources needed to maintain this vital healthcare facility for our patient's.

**Insurance Companies:** We are here to help answer any questions you may have regarding your insurance coverage and payments; however, your insurance is a contract between you, your employer, and the insurance company. Unless we are a provider with your plan, we are not a party to that contract. Unless we are participants with your plan, you may be responsible for a portion of or all of the charges.

If we are contracted with your insurance company, we will file your claims directly to your company. If we are not, we will supply you with the forms you will need to send to your insurance company for reimbursement. You will be required to pay our bill in full at the time you are seen. Please notify us if we are not contracted with your plan and we will look into becoming a provider for your plan. It is your responsibility to verify that we are covered providers with your insurance.

**Card on File:** Our office requires ALL patient's to have a credit, debit or HSA card on file. The card will be held in an electronically encrypted form and will NOT be accessible by the office staff. The card will be used to pay any charges that are not covered by your insurance. You will be required to sign a contract that will be kept on file for a period of 1 year or up to 1500.00 maximum per year. You will receive an e-mail notification 5 days prior to your card being charged. You can contact us within that 5 days period to dispute the charges or make other arrangements for payment. Once charged you will receive and emailed receipt. Please remember this policy does not affect your right to dispute any charges to your credit card.

**Office Visits:** Full payment for services is due at the time of your visit. We accept cash, checks and Visa/MasterCard credit cards. Co-payment and deductible amounts will be collected at the time of your visit. If you are not prepared to pay your co-pay, your visit will be re-scheduled. In order to charge on an account it MUST be previously approved and the account must be paid in full. Otherwise payment in full is due when services are rendered. Any patient that has had a bill sent to collections must pay any balances owed to the practice before they will be seen in our office.

**Surgical Procedures:** We will file insurance claims as a courtesy for patients requiring surgery. Surgery deposits are required, and payment is to be made at your pre-op visit. The deposits consists of your deductible (if not met) and your co-insurance or co-payment. You should contact the business office prior to our pre-op visit to discuss the amount expected. We will do everything we can to ensure your claim is paid; however, you are the responsible party, and you will be expected to pay any remaining balance.

**Obstetrical Care:** Payment for OB care is discussed individually. You will meet our OB insurance representative on your first or second visit to review expected charges and payments.

**No Show Policy:** A "no show" is someone who misses an appointment without cancelling it 24 hours in advance. No Shows inconvenience both our medical providers and other patients who need access to medical care in a timely manner. A failure to present at the time of a scheduled appointment will be recorded in our appointment scheduler as a "no show". The first time there is a "no show", the patient will be sent a letter alerting them to the fact that they have failed to show up for a scheduled appointment. If there is a second "no show", a fee of \$50.00 will be charged to your credit card on file. This fee is not covered under your insurance policy and is the patient's responsibility for paying. Another appointment will not be scheduled until the fee is paid in full. Multiple "no shows" may result in the termination of a patient from our practice.

**Referral or Authorization:** Many healthcare organizations require that you obtain a referral from your primary care provider (PCP) before you can be seen for specialty care. If your PCP has sent you to us to evaluate a problem, we ask that prior to your visit you call our office to confirm that your PCP has provided us with a referral. You will be responsible for any visits that are not authorized.

**Collections:** Any patient that has been placed in collections must pay any balance owed to the practice in cash before the practice will see them again.

**Assignment of benefits:** I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Dr. Lynore Martinez, MD, Santa Fe OBGYN LLC rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance

Patient/Responsible Party

Signature

Date

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If NOT patient; relationship to patient

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12/29/2014