James River OBGYN Financial Policy

Thank you for choosing James River OBGYN as your healthcare provider. We are committed to you and being a part of your treatment. The following is a statement of our financial policy, which we require you read and sign prior to any treatment. All patients must complete this information before seeing the provider.

Regarding Insurance

We may accept assignment of insurance benefits however, co-payments must be made at the time of service. The balance is your responsibility whether or not your insurance pays. We cannot bill your insurance company unless you give us your insurance information and an original insurance card to copy and keep on file. Your insurance policy is a contract between you and your insurance company. We are not party to that contract. Please be aware that some and perhaps all of the services provided may be non covered services and not considered reasonable and necessary under the Medicare program and/or the other medical insurance companies. You will be responsible for these balances.

Initial____________________

Returned Check Fees

There will be a fee of $35 returned check fee on all returned checks. In the event that a check is returned for insufficient funds, we will call your back to verify funds for any further checks that are presented for payment on your account.

Initial____________________

Collection Fees

In the event that your account is turned over to a collection agency, you will be responsible for all collection costs including reasonable attorney's fees.

Initial____________________

Missed Appointments

Unless an appointment is cancelled at least 24 hours in advance, our policy is to charge for missed appointment for ultrasound and Bone Density appointments at the rate of $25 per missed appointment.

Initial____________________

Fees for Letters

Your heath care provider will be more than happy to fill out any form(s) you may need. Please be advised that due to the time required to dictate and complete letters and forms, there may be a fee for this service. These costs are considered non covered services by your insurance company.

Initial____________________

Thank you for your understanding and the need for the financial policy. Please let us know if you have any questions or concerns. I have read the Financial Policy. I understand and agreed to the Financial Policy.

______________________________	________________________
Print Name	***Date of Birth***
______________________________	________________________
Signature of patient or person responsible	***Date***

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