

SCOTTSDALE OBSTETRICS & GYNECOLOGY, P.C.

(480) 945-4849 • FAX (480) 945-0989

ERIC M. REUSS, M.D., M.P.H.

Diplomate, American Board of Obstetrics and Gynecology

Financial Policy

Insurance:

It is your responsibility to make sure our office has your most up to date insurance information at time of service. YOUR insurance policy is a contract between *you* and *your* insurance carrier and we are not a party to that contract. As a patient, it is your responsibility to know your benefits, limitations, and insurance coverage including co-payments, deductibles, and co-insurance amounts. We are contracted with multiple insurance companies and are not responsible for knowing each individual's insurance plan coverage. As a patient you assume responsibility for any and all charges not covered by your insurance for treatment or diagnosis related to patient care and services provided. Payment is due at time of service.

Initials: _____

Balances:

It is your responsibility to keep your address, phone number, and email up to date with our office. Statements are sent to the address on file with our office; or an email is sent to you with a message stating that your billing statement is available for you to view through the Patient Portal, if you opted for paperless billing. Payments can be made through the Patient Portal, by phone, or by mail. As a courtesy, a phone call reminder will be sent to you at 10, 20 and 30 days after receipt of your statement. Account balances not paid within 45 days, will be charged a **\$25 late fee**. Past due balances may be sent to collections.

Initials: _____

Well Women (Preventative) and Problem Focused Exams:

A well women exam is when a healthy patient is seen for a routine screening; this is considered preventative care, which most insurance policies cover at 100%. A problem visit is one where a patient has a specific concern, symptom or complaint. We are required to submit claims based on the services you receive. **If we provide BOTH a well-women and problem focused exam then BOTH services will be billed.** Dependent on your insurance coverage, you may be responsible for a co-payment, co-insurance, or deductible amount related to the problem focused exam.

Initials: _____

Payment for Surgery and Maternity Care/Delivery:

We will obtain benefits from your insurance company in order to provide you with an estimate of your financial obligation for surgery or maternity care/delivery. This information will be provided to you and pre-payment arrangements can be made at this time. Feel free to ask any questions you may have related to coverage of benefits and how we determine estimated cost. Payment for surgery will be due prior to date of surgery. Payment for maternity care/delivery will be due by your **32nd week of pregnancy**. As you should be aware, insurance plans include a disclaimer that states, "this is not a guarantee of payment or benefits and benefits are determined when that claim is submitted and processed". After your insurance company has processed your claim, a statement regarding any unpaid balance will be billed to you. If you have a credit, the card used for payment can be credited back or a refund check can be mailed to you.

Initials: _____

Missed Appointment Fees:

As a courtesy, our office will notify you two days in advance of your upcoming appointment. If for any reason you are unable to make your scheduled appointment, we would appreciate and require a 24-hour notification of cancellation. Messages left on our voicemail after hours will count as notification. Late notice, no call/no shows and multiple reschedules will be charged a **\$50 fee**.

Initials: _____

FMLA/ Disability Forms and Medical Records: There will be an administrative **\$25 fee** charged for completion of forms. There is also a **\$50 fee** for medical records.

Initials: _____

By my signature below, I acknowledge that I have read and agree to the terms and conditions of the Financial Policy of Scottsdale Obstetrics and Gynecology.

Date: _____ **Patient Date of Birth:** _____

Patient Name (Print):

Signature of Patient or Patient

Representative: _____