



Dekalb Women's Specialists

Gynecological & Obstetrical Care

Financial Responsibility Policy

Patient's Printed Name: _____

I understand that I _____, or my guardian _____ will be responsible for paying any fees not paid by my insurance company.

I also understand that I am responsible for understanding the terms of my insurance coverage and benefits (deductibles, co-insurances, and copays). Dekalb Women's Specialists will assist me in the accurate filing of claims, but they cannot change claims to benefit me. The providers of Dekalb Women's Specialists may perform services and lab work that is not covered by my insurance. Once services are rendered, I agree to pay for them.

I understand any balances are to be paid in full before my next scheduled visit. If I am unable to pay the full balance I will pay in accordance to the payment plan arranged by Dekalb Women's Specialists. I will attend all scheduled meetings with my financial counselor and I understand that failure to follow financial policy will lead to my account being sent to collections and my dismissal from Dekalb Women's Specialists. Balances are to be prior to or at the time that services are rendered.

I understand that if I do not adhere to the payment schedule set forth that I will be subject to collection methods, which can incur additional costs up to 40% over my charges.

Most lab work is performed by an independent laboratory. I understand that I will be billed separately for those services. If I have questions about my lab bill, I will address them to the performing lab or its representative stationed in the office. LabCorp is the preferred lab for Dekalb Women's Specialists and is the only onsite representative. We will always try to send your labs to your insurance carriers preferred laboratory. Other labs that we may use include Quest Diagnostics, Natera, and MDL. I understand that Dekalb Women's Specialists cannot waive fees for services that are rendered by the laboratory.

If I am a Medicaid recipient, I understand that should I lose my eligibility, or if I should change my CMO to any payer other than Peachstate or Caresource Health plans, then I shall pay for services rendered or may be dismissed from the practice.

If I am not approved by SSI, Medicaid of Georgia, I understand that all charges will be billed to me or my guardian.

I understand that there are fees for copying medical records for my personal use, as well as completion of FMLA/ Disability forms.

Patient Signature

Date

Guardian Signature