FINANCIAL POLICY

Welcome to Maricopa OB/GYN. We are committed to giving you the best care possible. We would like to take this opportunity to inform you of our office policy.

We will bill insurance claims as a courtesy to our patients provided we have your current insurance information and any necessary referrals. Should your insurance require a referral, and we have not received it prior to your appointment, you will be responsible for payment at the time of service. We accept payment from insurance companies, but require that you pay your portion, including co-pays, deductibles or coinsurance at the time of service.

Changing or re-coding claims once they have been billed constitutes fraud and we **do not** do this under any circumstances.

This office bills **only** for services performed by our providers. The laboratory company is a separate entity, and will bill you or your insurance company for labs that are performed. If you have any questions regarding your lab bill, please contact that laboratory or your insurance company.

As a courtesy, we attempt to contact every patient to remind them of their appointment; however, it is the responsibility of the patient to arrive for their appointment on time. We ask that you notify us 48 business hours in advance to cancel and/or reschedule your appointment. Please be aware that failure to do so may result in a missed appointment fee of $25.00, and the fee will range from $50 - $100 for a missed procedure appointment.

It is your responsibility to notify our office if there is a change of name, insurance coverage, residence, and/or phone number.

I have read the above Financial Policy. I understand and agree to these terms. __________
(Please initial)

Acknowledgement of Notice

I acknowledge receipt of the Notice of Privacy Practices for Maricopa OB/GYN. __________
(Please initial)

Release of Information

I authorize my Personal Health Information to be disclosed as specified below:

Primary number:__________________________________. Acceptable to leave a message on this number: ☐YES ☐NO

Secondary number:________________________________. Acceptable to leave a message on this number: ☐YES ☐NO

☐ To the following family member(s) or other person(s):

______________________________________/__________________________________/______________________
Name **Relationship** **Phone Number**

______________________________________/__________________________________/______________________
Name **Relationship** **Phone Number**

____ ____/____/____
PATIENT NAME (Please Print) **DATE OF BIRTH**

____ ____/____/____
SIGNATURE OF PATIENT/GUARDIAN **DATE**