

MIDWEST MATERNAL-FETAL MEDICINE
A Division of Signature Health Services, Inc.

FINANCIAL POLICY

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please feel free to ask any questions about our fees, financial policy or your financial responsibility for services.

Please verify your address and insurance coverage and bring your insurance card to our office each time you visit.

We will file insurance claims for professional services rendered. Patient deductibles, co-insurance, co-payments and payment for non-covered services are due at the time of service. Co-payments are collected by the receptionist when you check in for your appointment. Due to our physicians being specialists, your insurance may require co-payments for each visit. We will provide you with a receipt for all charges billed and monies collected.

Cash, checks, MasterCard, Visa, debit cards and money orders are accepted forms of payment. Our policy includes a \$20 fee for returned checks.

INSURANCE

It is important for you to check your insurance plan in detail prior to your visit. It is your responsibility to know your coverage and to pay at the time of service for any services not fully covered by your plan or any co-payments that are required by your plan.

Many insurance plans require a written referral or referral number for the specialty care provided by our physicians. Please make all necessary arrangements to obtain a referral prior to your visit. If a referral is required and you did not obtain one, we will provide a responsibility statement for your signature and you can pay for the visit at the time of service, or you can reschedule your appointment.

For all charges that are filed to your insurance company, in the event the claim is denied for any reason, the full balance becomes your responsibility to pay. We will notify you so that you may contact your insurance company and assist us in facilitating payment. Please remember that ultimately our services are provided to you, not your insurance company; therefore, payment is the responsibility of the patient. A billing representative will contact you regarding outstanding balances, and by signing below, you agree that our staff may leave a message indicating there is a past due balance.

PAYMENT ARRANGEMENTS

If a patient and/or guarantor cannot make payment in full at the time of service, the patient must speak with the billing representative. The billing representative will develop an appropriate payment arrangement.

COLLECTIONS

If it becomes necessary for your account to be placed in collections due to non-payment, the patient and/or guarantor are responsible for all associated collection costs.

Thank you for reviewing our financial policy. We appreciate your compliance with this policy. Please let us know if you have any questions or concerns regarding your financial responsibilities.

ACKNOWLEDGEMENT

I have read and understand the Financial Policy.

Patient and/or Guarantor

Date

Witness

Date