OFFICE PAYMENT POLICY

As part of our commitment to offer excellent medical and professional care to you and your family, we would like to present our office payment policy in order to minimize misunderstandings about fees. Our fees and methods of payments are comparable with other Gynecologists and Obstetricians in the Atlanta area. We ask for payment at the time of service. This includes payment for the office visit and any tests that are performed. We commonly require payment at the time of check-in.

Any laboratory tests which require an outside lab company to perform will be billed separately by that company.

As a courtesy, we will file all applicable office and hospital charges with your insurance carrier(s). By your signature below, you authorize and request that insurance payments be made directly to ***My***OBGYN, P.C. **However, you are ultimately responsible for all charges. We advise that you familiarize yourself with the benefits of your plan. Prior to any procedure, including the delivery of your infant, we will assist you in determining your portion of the bill. This usually includes any un-met deductible, co-payment and co-insurance which are to be paid prior to the procedure or your delivery. We accept Cash, Checks, Master Card, Visa, American Express or Discover.**

After you have paid for your visit, you will receive an itemized statement. You can attach this copy to your insurance claim and send it to your carrier for processing if necessary.

We are providers for several HMO and PPO plans, in which case the above may not apply. However, you are responsible for your co-payment, deductible, or other non-covered services as set by your insurance carrier. Co-payments are collected at the time of service. **If your insurance carrier requires a referral number to receive services form our office, it is your responsibility to contact your Primary Care Physician to obtain the number prior to your office visit.**

This policy is offered in an attempt to develop and sustain a continued professional and pleasant relationship. Your cooperation is greatly appreciated.

There will be a monthly statement fee of $8.00 on any unpaid balance over 60 days and a finance charge of 1.5% on any unpaid balance over 60 days. Your prompt payment is appreciated!

CONSENT TO TREATMENT AND PRIVACY

I authorize and consent to all examination and treatment necessary for the care of the patient named below and consent to any and all procedures incident to such treatment which are deemed necessary by the physicians and clinicians of ***My***OBGYN, P.C. including but not limited to blood and urine tests, drug tests, and any other diagnostic procedures or treatment. I authorize the release of all medical records to the referring and family physicians and to my insurance company, if applicable. I allow fax transmittal of all my medical records, if necessary. I further acknowledge that I have been given the opportunity to review the Notice of Privacy Practices of ***My***OBGYN, P.C.

Name of Patient:_____

I have read and understand the above policies and consent to treatment.

_____ Date _____

Signature

Printed Name:_____ Relationship to Patient:_____