Southcoast Woman's Care

PATIENT FINANCIAL OBLIGATIONS

Patient Name: _____Date of Birth: _____

1. Co-payments must be paid at the time of your visit. We accent cash, checks and credit card payments.
2. There will be a $25.00 fee charged for all checks returned to us due to insufficient funds.
3. Your claim will be processed through your insurance company (ies) provided that we have ALL the accurate and complete information.
4. You are responsible for any charges incurred as a result of your visit that insurance doesn't cover.
5. If you have no insurance, payment is expected at the time of service.
6. It is your responsibility to obtain a referral from your primary care physician prior to your visit if your insurance requires one.
7. If you do not provide us with a referral prior to your visit, we reserve the right to reschedule your appointment.
8. If you fail to make prior arrangements with us and your account balance extends beyond 90 days, your account will be turned over to a collection agency that may report you to the credit bureau.
9. You will be required to make payment arrangements for any past due balances.
10. A minimal fee of $15.00 is charged for completing any disability forms.
11. If your insurance company requires you to use a specific laboratory and/or facility, it is your responsibility to notify us.

Please ask if you have any questions about your financial obligations.

I have read and understand the Patient Financial Obligations Policy. By signing below, I agree to comply with this policy.

_____ _____

Signature of Patient Date