

UNIVERSITY PERINATAL CONSULTANTS FINANCIAL POLICY

IF YOU DO NOT HAVE INSURANCE COVERAGE

If you do not have insurance coverage, you are responsible for the total amount of payment at the time of your visit. We accept case, checks, Visa and MasterCard.

IF YOU HAVE INSURANCE COVERAGE:

We will bill most insurance carriers if proper documentation has been provided to us. We will also bill most secondary insurance companies for you. Co-payments and deductibles are due at the time of service. We accept cash, checks, Visa and MasterCard. Since your agreement with your insurance carrier is a private one, we do not routinely research why an insurance carrier has not paid or why it paid less than anticipated for your care. Most insurance policies that cover maternity benefits also cover our services, but not always. As our practice is considered a specialty practice, some insurance companies require your OB/GYN or primary care physician to place a referral (i.e. notify the insurance company of your need to be seen by our physicians) prior to your arrival at our office. It is your responsibility to contact your insurance carrier to find out what they require. It is your responsibility to insure that your physician has performed the proper referral to your insurance company.

MEDICAID PATIENTS: You must present a valid card at the time of services.

NON-COVERED SERVICES: Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or upon notice of insurance claim denial.

ASSIGNMENT OF INSURANCE BENEFITS Patients with insurance please read and sign below. I hereby assign all medical and /or surgical benefits, to include major medical benefits to which I am entitled, private insurance and other health plans, to University Perinatal Consultants/ University GYN and OB Consultants. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Signature: _____ Date: _____

I have read, understood and agreed to the above financial policy for payment of professional fees. The patient is ultimately responsible for all professional fees.

Signature: _____ Date: _____

