CAMDEN OB/GYN AUTHORIZATIONS AND PAYMENT POLICY

Payment is expected at the time of service. Due to the high costs of billing, patients unable to make payment at the time of service will be rescheduled. Accepted methods of payment include cash, credit card, checks, and debit card.

Your insurance coverage is a contract between you and your insurance company. As a courtesy, we will file your insurance claim providing you furnish all pertinent information. However, if your insurance company does not pay the practice within a reasonable period, you will be responsible for payment.

It may be necessary to send some specimens to a reference laboratory for testing, as we provide only the basic laboratory services. If such services are provided, you will receive a separate bill from the laboratory. In addition, you will receive a separate bill from services associated with hospital stays, anesthesia, pathology, and radiology. All billing questions should be directed to the facility from which you received the bill.

15 Minute Late Policy: If you are more than 15 minutes late for your appointment, you may be asked to reschedule.

No Show Policy - Patients who schedule appointments but fail to show up are documented as "no shows". A 24 hour notice for cancellation is required by this office. Failure to do so could result in a $ 30.00 charge and this charge is not covered by insurance. Patients with multiple "no shows" for any appointment type may be terminated from the practice. Please be courteous to your provider and fellow patients, and cancel your appointment as soon as possible.

AUTHORIZATION AND AGREEMENT FOR TREATMENT

CONSENT TO TREATMENT: I understand that medical treatment is necessary and that such medical care, treatment, and procedures will be performed by employees of Camden Ob/Gyn. I hereby grant my authorization and consent to such treatment and procedures.

AGREEMENT TO PAY SERVICES: For consideration for care and treatment, I promise to pay all co-insurance and non-covered charge amounts for services rendered at the time of service. I also agree that I will be personally liable for legal fees incurred in the collection attempts against debts that accrue with Camden Ob/Gyn.

RELEASE OF MEDICAL INFORMATION: I hereby authorize Camden Ob/Gyn to release my medical information in connection with these services for health insurance purposes or to my personal physician or to a referring physician. I authorize by my signature below direct payment of all benefits to Camden Ob/Gyn and authorize submission of insurance forms with this signature on file.

PRIVACY PRACTICES PATIENT ACKNOWLEDGEMENT: I acknowledge that I have been provided with an opportunity to receive the Notice of Privacy Practices for Camden Ob/Gyn. In reviewing the Notice, I also acknowledge that I been provided the opportunity to ask questions regarding the Notice and its contents.

I HAVE READ THE ABOVE ACKNOWLEDGEMENTS AND AGREEMENTS AND FULLY UNDERSTSAND THE SAME,

PATIENT/GUARDIAN SIGNATURE ______________________________ DATE____________