About Our Fees

Dear Patient:

Our fees are based on the time our providers spend with you during your visit, the complexity of your medical condition, and any treatment they provide. But proper attention to your care also requires that they - or members of our staff – spend *additional* time beyond that which we spend with you in the office. Such time may be used to, but is not limited to:

- Create or maintain your permanent medical record.
- Review, interpret, and document lab test results and communicate those results – orally or in writing – to you.
- Review current X-Ray or scan results, compare them with reports of previous results if applicable, and when the studies are abnormal, consult with the radiologist.
- Prepare and mail consultation reports and letters to patients who need to come in for a follow-up visit to follow-up on a previous medical problem.
- Consult via phone about your case with referring or consulting physicians and other health care providers.
- Prepare referral letters to additional specialists or primary care providers, as needed.
- Prepare patient education materials.
- Conduct medical research relevant to your case.
- Communicate with pharmacies about your prescriptions.
- Complete insurance applications and claim forms.
- Conduct utilization review negotiations with hospitals and insurance companies.
- Review and manage hospital records.
- Draft letters of necessity to obtain medical services, instruments or prescriptions that you need.
- Arrange for hospital admission and surgery and follow-up consultations with nurses, attending physicians, and residents.
- Draft reports and forms, including home health care orders and other service orders.

All these activities add to our cost of doing business. We are committed to providing you the best possible care at the lowest cost. We hope this explanation of our fees has been helpful. With you, our patient, we look forward to a lasting and healthy relationship.

FINANCIAL POLICY:

Thank you for choosing us as your health care provider. This following is a statement of our Financial Policy.

* Full payment is due at the time of service. We accept:, Visa, MasterCard, checks, and cash.

*We participate in a variety of insurance companies. It is your responsibility to make sure we are a participating provider of your insurance carrier prior to your office visit.

* All co-payments and deductible amounts are due prior to treatment. In the event that you have, or change to an insurance plan in which we do not participate, full payment of services rendered will be due at that time.

* If it becomes necessary to bill you for amounts due at the time of service, a billing fee will be applied.

* Our practice is committed to providing the best treatment for our patients, and we charge usual and customary fees for our area. Thus, you are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

NOTE: If you come to your preventative health care service visit (an annual) with symptoms of an active medical problem that your provider needs to address, additional evaluation and management services may be performed on the same day or you may schedule an appointment to receive that service at a later date. The associated charges for this additional service may be handled differently by your health plan than your preventative service and you may be personally responsible for additional co-payments, deductibles or other out-of-pocket expenses as determined by your health plan.

PATIENT CONSENT, AGREEMENT OF FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS:

I, the undersigned, consent to the use and disclosure of my protected health information for treatment, payment and operations and such other purposes that are permitted under the Federal Health Insurance Portability and Accountability Act (HIPAA) without a written authorization. I accept that I am financially responsible for all services rendered on my behalf by Southeast Obstetrics and Gynecology, PC (the practice). For those insurance plans for which the Practice accepts assignment. I accept personal responsibility for all co-payments, deductibles and non -covered services, as dictated by my insurance coverage. I authorize payment directly to The Practice for services which The Practice accepts assignment. I have read and agree to the Financial Policy. A copy of this agreement may be used in place of the original. I certify that the information stated on this form is correct.

_____ _____

Signature of Patient Date

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE (HIPAA):

By signing below I acknowledge that I received a copy of Southeast OB/GYN's notice of Privacy Practices.

_____ _____

Signature of Patient or Parent/Legal Representative Date

If not the patient, please print your name and indicate your relationship to the patient:

_____ _____

Printed Name Relationship to Patient

PATIENT'S AUTHORIZATION TO RELEASE PROTECTED MEDICAL INFORMATION (THIS IS OPTIONAL): By signing below, I am authorizing said family member, friend, or other person to receive information regarding my health and protected health information. **To the patient:** Please note if no person is stated below, you will be the only one to make appointments, call for prescription refills and/or discuss health concerns. Please note that you at any time can take a person on/off your list.

Names of persons allowed to get the above mentioned information (please print):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____ _____

SIGNATURE OF PATIENT/LEGAL REPRESENTATIVE **DATE**