2017 Financial Policy Statement

Welcome to Fairfax OB-GYN Associates, P.C., L.A.R, M.D., P.C., R.L.C., M.D., P.C. We are pleased you have chosen our practice for your medical care. We ask that you **carefully read** and sign the following statement. We must emphasize that, as your medical care provider, our relationship is with you and not your insurance carrier. As a courtesy to you, we will file your claim with your insurance company. However, you are the sole responsible party for all charges incurred and guarantee payment thereof. Benefit eligibility obtained from your insurance company is for informational purposes only and not a guarantee of payment. If we are contracted with your insurance company, we will accept assignment. You will be responsible for your payment portion at the time of service. **All balances become your responsibility when the account reaches 45 days from the date of service**. Failure to provide necessary referrals and/or authorizations or failure to provide current, accurate billing information will result in all charges for services becoming the sole responsibility of the patient/responsible party. You are expected to understand your benefits coverage and responsibilities. This includes obtaining any referrals and/or authorizations which your insurance company might require before care is provided.

* All co-pays, co-insurance and deductibles are due and payable at the time services are rendered. If we do not have a contractual obligation with your insurance company, you are responsible for 100% of the payment at the time services are rendered.

All account balances still owed to Fairfax OB-GYN Associates, P.C., L.A.R., M.D., P.C., R.L.C., M.D., P.C., when the account reaches 75 days from the date of service will be referred to an outside agency for collection. Accounts referred to a collection agency will incur a fee of 28% of the principal balance, to cover collection/attorney fees and interest.

In consideration of the services performed by Fairfax OB-GYN Associates, P.C., L.A.R., M.D., P.C., R.L.C., M.D., P.C., you agree to abide by the terms of this Financial Statement.

_____ _____

Patient or Responsible Party Signature **Date**

I, _____ hereby authorize Fairfax OB-GYN Associates, P.C., L.A.R., M.D., P.C, R.L.C, M.D., P.C., to apply for benefits on my behalf for services rendered. I certify that the information I have provided is correct. I authorize the release of any necessary information, including medical information for this or any related claim to the health insurance I have provided. Should collection action become necessary, I further authorize the release of demographic information including cell phone numbers to outside agency to facilitate collection of my debt. I permit a copy of the authorization to be used in place of the original. I may revoke this authorization at any time in writing.

_____ _____

Patient Signature **Date**

_____ _____

Witness **Date**